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ABSTRACT

This text is designed to assist state, regional, and local education agencies and other collaborating agencies to improve interdisciplinary and interagency service coordination for children, youth, and adults with disabilities in accordinace with the Individuals with Disabilities Education Act (IDEA) and other related statutes. The training guide supports the mission of Regional Resource Centers by providing technical assistance and training to improve the quality of service coordination. Chapter 1 offers a philosophy for interdisciplinary, interagency service coordination. It explores the emergence of interagency coordination within several human service sectors and examines services as an integrated system to address the needs of individuals and their families. This chapter also includes a summary of provisions for interagency coordination in recent laws. Chapter 2 outlines eight essential functions of interdisciplinary and interagency service coordination and examines the roles of the service coordinator. The third chapter focuses on the practical aspects of developing and managing interagency service coordination and presents a 10-step strategic plan for implementation. Chapter 4 offers examples of service coordination in operation for infants and young children; pre-adolescents, teens, and their families; and young adults. Discussion questions accompany each of the 11 case examples. The final chapter reviews basic evaluation principles and reinforces the concept of evaluation for improvement and renewal. The focus is on assessing service outcomes, systems change, and improvement at local and state levels. (Contains 40 references.) (DB)

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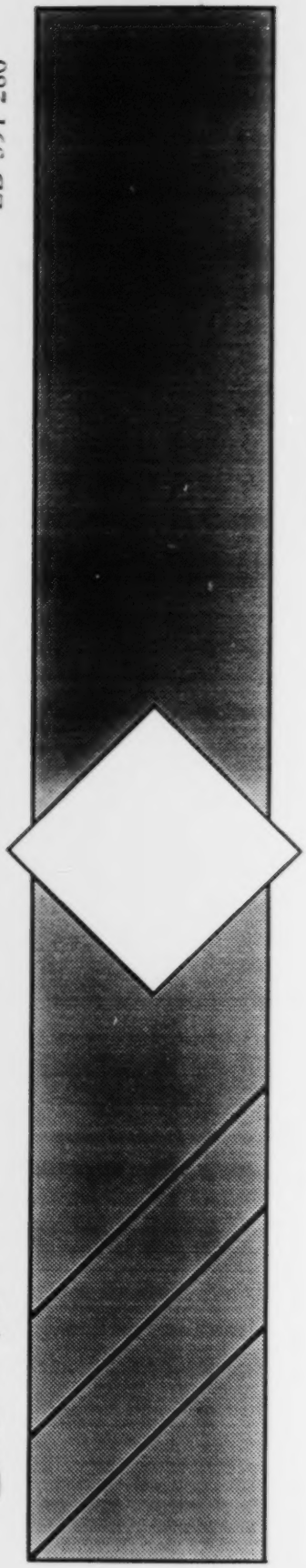

Interagency

Interdisciplinary

Service Coordination

A Training Resource

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INTERAGENCY, INTERDISCIPLINARY SERVICE COORDINATION

A TRAINING RESOURCE

Developed for the
Bureau of Special Education, Iowa Department of Education,
Des Moines, IA
and the Mountain Plains Regional Resource Center,
Drake University, Des Moines, IA

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INTRODUCTION

Rationale and Relationship to the Mission of the Regional Resource Centers

This text is designed to assist state, regional, and local education agencies and other collaborating agencies to improve interdisciplinary and interagency service coordination for children, youth, and adults with disabilities in accordance with the Individuals with Disabilities Education Act (IDEA, PL. 101-476) and other related statutes. Legislation concerned with the inclusion of persons with disabilities in mainstream education, health, and human services has been evolving over the past several decades, and the nation is now looking beyond service implementation to its impact. There is a national focus on the effectiveness of service coordination for children, youth, and adults of all ages.

This document supports these goals of the regional resource centers:

- to meet the changing and emerging needs of education and human service professionals who serve persons with disabilities
- to provide technical assistance and training to improve the quality of service coordination for children, youth, and adults with disabilities

The Iowa Department of Education, Bureau of Special Education, is working in conjunction with the Mountain Plains Regional Resource Center to develop training based on the concepts presented.

Due to the increasing importance being placed on effective coordination of services for children and families from infancy through adulthood, there is a growing need for service coordination training materials. The following chapters reinforce that need for a wide audience of parents, general and special education teachers, early intervention specialists, administrators, training coordinators, school-business liaisons, transition specialists, and other agency personnel at all levels.

Need for Stronger Connections among Services

The following chapters are about ideas, philosophies, and principles that have stimulated and guided a movement toward interagency partnerships and shared responsibility for the development and well-being of all individuals. More importantly, they urge changes in the ways people think

about individuals with special needs and about how education, health, and human service agencies should respond.

There are many reasons why communities across the nation have made renewed commitments to creating stronger linkages among service agencies:

- The service system is increasing in complexity, creating difficulties for individuals and families with multiple needs who require a variety of services from different community agencies.

- There remain many *cracks* in the service system. The term is often used to describe instances in which individuals and families in need must pursue services from several separate and uncoordinated sources or the individuals and families cannot access or effectively utilize the services.

- There is a recent surge of interest in integrating services. Educators are integrating services across disciplines; health professionals are addressing problems from many perspectives; and early intervention specialists are linking the resources of several service sectors: medicine, public health, social services, mental health, family support, and others.

- In the past decade, the successes and benefits of service coordination in health care, mental health, and mental retardation have gained the attention of educators and policymakers.

- Human service agencies are seeking ways to empower consumers and families to make decisions about services, assume more control, and learn to do better at managing educational and personal development programs.

- Recent research and practice have confirmed the value of early intervention services in preparing infants, toddlers, and young children to benefit from therapeutic and educational services. In response, national and state legislators have mandated greater roles for health and human services in providing services to children in the early years.

- Congress and the U.S. Government have recognized that education, health, and employment outcomes for all individuals with disabilities remain a great concern and have called for expanded state and local coordination efforts.

- Business and industry are also becoming important players in the human development effort and are forming partnerships with education and community services to help produce a better work force and improve the quality of life.

These are just a few of the major reasons for increased attention to interagency service coordination. Agencies are now realizing it is much wiser to serve an individual as a whole person and address the needs in a way that coordinates the services with one another. Service systems are finding shared approaches to addressing human needs bring the combined thinking, planning, and resources of many agencies to bear upon the problems of an individual more efficiently and more effectively.

Service coordination represents a range of relationships among disciplines and service agencies. Diversity in the change process must be encouraged because no single solution for improving coordination can be applied to all individuals or all communities. All must bring their knowledge and skills together to address the complex needs of individuals in a community.

Challenge for Interdisciplinary and Interagency Pioneers

The challenge for pioneers in service coordination is to look beyond traditional interdisciplinary and interagency relationships to communicate and interact

- across multiple disciplines and agencies (general and special education, employment and training, health and social services, and many others)

- across the educational continuum (early childhood, elementary, secondary, postsecondary, and adult education)

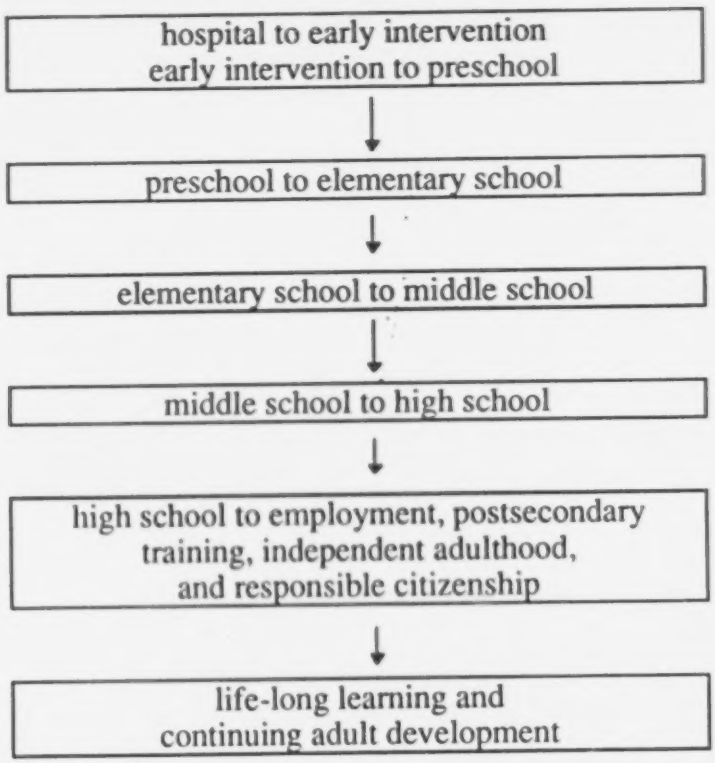
- across multiple agency service boundaries

- across categories of individuals (with disabilities, with economic and educational disadvantages, at risk of dropping out of services, with limited English proficiency, etc.)

- across political and philosophical barriers (differing agency views on the role of education and human services)

- across service-provider and consumer-family perspectives

Embracing the importance of connections, the framework of this training resource includes the continuum of individual passages:


hospital to early intervention
early intervention to preschool
preschool to elementary school
elementary school to middle school
middle school to high school
high school to employment, postsecondary training, independent adulthood, and responsible citizenship
life-long learning and continuing adult development

The ambitious goal of interdisciplinary and interagency coordination among service agencies has a long history, yet most educators and human service providers remain confined within their own segments of the continuum. For example, a tenth-grade special educator or community college instructor may seldom look back along the continuum to understand what went on in earlier years in families and schools for children with special needs. Similarly, she/he may not look ahead along the continuum to get to know the post-school array of services in the community and the complex choices that

students face upon leaving school. A job training professional seeking to assess the work skills of young adults may not consider the early influences of family, health, or education.

Emphases of the Chapters

It is vital that interdisciplinary and interagency pioneers in service coordination share understanding of

- values and philosophical principles underpinning collaboration
- definitions and elements of service coordination
- principles for planning and managing service coordination
- service coordination strategies within the continuum from infancy to adulthood
- methods for evaluating the success of service coordination efforts

You'll find each chapter underscores the theme of life-long learning and development and fosters acceptance of shared responsibility among all agencies and disciplines for improving service outcomes and promoting systems change.

CHAPTER 1: The Emergence of a Philosophy for Interdisciplinary, Interagency Service Coordination introduces the philosophical roots of service coordination. It explores the emergence of interagency coordination within several human service sectors and examines services as an integrated system that can address the needs of individuals and their families. The chapter also includes a summary of provisions for interagency coordination in recent laws.

CHAPTER 2: The Defining of Interdisciplinary, Interagency Service Coordination outlines eight essential functions of interdisciplinary and interagency service coordination and examines the roles of the service coordinator.

CHAPTER 3: The Planning and Managing of Interagency Service Coordination focuses on the practical aspects of developing and managing interagency service coordination and presents a ten-step strategic plan for implementation.

CHAPTER 4: The Coordinating of Services from Infancy to Adulthood presents for your analysis examples of service coordination in operation for infants and young children, pre-adolescents and teens, and young adults. Accompanying questions encourage personalized applications.

CHAPTER 5: The Evaluating of Service Coordination for Program Improvement reviews basic evaluation principles and reinforces the concept of evaluation for improvement and renewal. The focus is on assessing service outcomes, systems change, and improvement at local and state levels.

Remember, no document can tell you everything you need to know about designing and implementing interagency partnerships. The methods you use in your community will be uniquely yours. At best, this resource will provide useful ideas and alert you to some of the obstacles you may encounter. The leadership is up to you.

Chapter 1: The Emergence of a Philosophy for Interdisciplinary, Interagency Service Coordination

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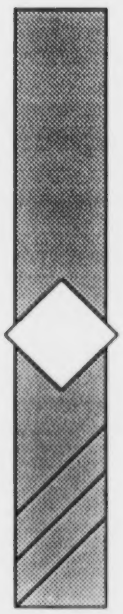

CHAPTER 1: The Emergence of a Philosophy for Interdisciplinary, Interagency Service Coordination

Philosophical Roots of Service Coordination

In recent years, there has been much discussion of changing philosophies and new paradigms in education, rehabilitation, and human services. Tom Kuhn introduced the term *paradigm shift* in his book, *The Structure of Scientific Revolutions* (1973).

> Definition--A *paradigm* is a framework, model, or set of assumptions that can guide how people think about a social problem and how they design an intervention to solve a social problem.

Paradigms provide new sets of beliefs that change the way service providers respond to human needs and raise a question about changes needed to improve collaboration: Whom or what should be the focus of intervention--the individual (individual-deficit orientation), the environment (environment-deficit orientation), or both (interactionist orientation)?

Theory/ Paradigm	Assumptions and Strategies
Individual-deficit orientation (medical model)	The cause of deficits or failures rests within the individual and his/her body. An individual does not progress satisfactorily in services because of inadequate cognitive, behavioral, sensory, motor, linguistic, medical, and/or physical characteristics (Salvia & Ysseldyke, 1988). In the same way that a disease is understood as being owned by the infected individual, learning problems are thought of as the exclusive property of the individual (Fedoruk, 1989). Intervention strategies involve assessing individual attributes, correcting conduct disorders, and remediating for sensory deficits.
Environment-deficit orientation (behavioral model)	While factors internal to the individual may make him/her more or less responsive to the environment, these factors are not the chief cause of poor outcomes. Since behavior is learned, an individual fails to progress in services because of inappropriate or inadequate environmental circumstances. Intervention strategies involve assessing the learning environment, the relationship of the characteristics of the service providers to individual achievement, professional-consumer ratios, service arrangements, family involvement, and socioeconomic status.

Interactionist orientation (contextual/ sociological model)	Learning and behavior deficits are products of inappropriate individual-environment interactions. Approaches to remediating deficits in learning, development, or physical health are shifted away from the search for causes within the individual and toward specifying the conditions under which different individuals can and will learn and progress (Wixson & Lipson, 1986). Intervention strategies involve assessing individual-environment interaction, professional-client interaction, peer interaction, and family support for service participation. The interactionist model is most useful for examining service coordination because it considers the individual, the environment, and the interaction between the two. It also shifts the focus of efforts to intervene in human problems away from searching for causes of problems toward defining the conditions that will lead to individual progress. Intervention strategies require the shared responsibility of the total community as many sectors provide different but complementary services essential for helping the individual maximize his/her potential.

Key to planners and coordinators working together to deliver services is understanding the assumptions that underlie agency policies and practices and accepting that after looking at all aspects of human problems (within the individual, the environment, and the interaction between them), solving the problems depends upon applying the sets of assumptions. Here are two illustrations of the interactionist view:

- Factors in the individual and in the individual's environment interact in different ways for each person. For example, having a physical disability may not create problems in learning, but the disability in combination with environmental factors may contribute to the individual's inability to perform necessary social roles. One of the most important social roles for a child is that of school student. Obstacles in the school environment interacting with the disability may prohibit access to classrooms, definitely affecting learning. Providing devices to enable mobility solve one aspect of the problem--that within the individual. The second part of the problem--the inaccessibility--requires a change in the school's response to the individual. The solution requires accommodations.

- An important social role for an individual is that of parent or family member. A chronic health condition combined with the stresses of being a parent who wants to care for others may create substantial problems for the family as a whole. Providing treatment for the health condition addresses one aspect of the problem--that within the individual. The second part of the problem is the family's response to the individual. An interactionist solution combines treatment with family intervention and support to help the other family members cope with the impact of the individual.

Recent Shifts in Service Philosophies

Following are comparisons of traditional and new approaches:

Traditional Approaches	New Approaches
Educational and developmental services for children with special needs begin in elementary school.	Prevention is being emphasized, and early intervention and early childhood education programs begin in the first year of life.
Young children enter segregated, special preschool programs.	Young children are integrated into preschool programs with nondisabled peers.
Children with special needs are offered pull-out programs in segregated settings.	Children are provided resource supports within the regular classrooms.
Preparation of youth for employment and careers involves simulated work experiences.	Preparation for employment involves real-world work experiences in community-based settings.
Social, family, and health services are offered in separate centers.	Services are co-located within the community and often are provided in the homes.
Large institutional facilities serve children and adults with severe disabilities.	Small residential programs serve children and adults with severe disabilities.
People are denied admission into postsecondary education and work training programs.	People receive support services through community colleges, universities, and work training programs.

The new approaches and their underlying service models are more likely to focus on changing the structure of services to accommodate for weaknesses and maximize strengths of the individuals as they are integrated in mainstream environments.

Changes in Service Philosophies

To understand how disciplines and agencies must alter to collaborate, it is helpful to review how changing service philosophies have shaped education and human services.

Human Potential Movement

Many theorists in psychology (Fromm, Rogers, Erickson, May) refer to the human potential movement as a philosophy founded upon the belief that all individuals have a basic desire to grow and develop in positive ways. This movement has been called a philosophical revolution for persons with disabilities and disadvantages. Educational and human services programs embracing the human potential ideology subscribe to the following:

- Our social policies should reflect the imperative that society has a responsibility to provide supports and opportunities to disadvantaged citizens.
- Society must defend the basic right of all citizens to life, liberty, and the pursuit of happiness, which includes equal educational and social service opportunities for all.
- All children can learn and have a right to education and support services appropriate to their developmental levels.
- All citizens have an inalienable right to resources and environments that support positive growth and development in children, youth, and adults whether they are disadvantaged, ill, and/or disabled.

General System Theory

General System Theory has changed the way people think about their relationships with others, with themselves, and with their physical and cultural environments. Its basic premise is this: The universe operates as a multitude of interrelated systems rather than in discrete units. People can understand systems only by contemplating them as relationships within wholes (ecosystems), not by studying individual parts in isolation.

There are three essential corollaries: 1) systems are greater than the sums of their parts, 2) systems are dynamic, and 3) when one part of a system changes, the totality is changed.

General System Theory is important to leaders in interagency service coordination because what they do affects many interconnecting systems. It requires consumers to be viewed as systems--dynamic wholes that are greater than the sum of their parts and whose existence is altered through interaction with other systems. People are complex, open systems that are in continuous interchange with other systems within their environments. The living web analogy elaborated by Von Bertalanffy (1968) and Sutherland (1973) is a powerful paradigm of biological, social, and emotional life.

Just as consumers are systems, so are the networks created to serve them. General System Theory offers a framework for understanding complex relationships among organizations or social networks. Within human services, the construct can help practitioners recognize shared problems and collaborative solutions among disciplines and agencies.

Because interrelatedness is so central to system thinking, the principles underlying interdisciplinary communication and collaboration are logical outgrowths. General System Theory suggests specialists from diverse fields can better work together if they develop a common vocabulary to discuss human behavior and needs, a shared set of broad philosophical principles, and flexible response mechanisms that encourage integration and synthesis.

Normalization Principle

The principle of normalization originated in Scandinavia and gained popularity in North America throughout the 1970s (Nirje, 1976; Wolfensberger, 1972, 1983). The normalization principle is closely related to that of individual rights and freedoms in a democracy and spurred the early foundations of a civil rights movement for persons with disabilities.

Normalization means letting the individual with a disability obtain an existence as close to normal as possible, meaning at least equal in quality to that of citizens with no identified disability. Culturally normative means are used to enhance or support behavior, appearance, experience, status, and reputation (Wolfensberger, 1972). The definition reflects a shift in society's response to persons who are deviant (different) from one of banishment and segregation to an effort to reverse deviancy by restoration, rehabilitation, and reintegration.

The normalization principle can be applied to any profession, agency, or individual consumer. The normalization ideology is more comprehensive than disability laws and extends into day-to-day human service practices and relationships among people (McWorter, 1986).

Normalization's value system is

- consistent with ideals upon which western democracies and their legal structures are based
- disseminated and applied through established training and evaluation methods
- well known and included in the curricula of manpower development programs across North America
- relevant to human services in general rather than to a narrow specialty (Wolfensberger & Thomas, 1983)

Community Integration Philosophy

Community integration practices were influenced by adherents of the normalization principle and incorporate the concepts of civil liberty, least restrictive environment, treatment rights, care vs. cure, life quality, and system coordination. Normalization of service environments, social integration, and advocacy for the individual have become hallmarks of service coordination and the philosophy of self-determination.

Individual Liberty Philosophy

Over the years, philosophies about freedom and autonomy, learning, and the potential to improve the mental, physical, and emotional capacities of individuals with disabilities have changed dramatically.

Stage 1 Dependence (1900-1940s)	State of devalued status/neglect social concern/benevolence physical intervention/medical treatment educational and psychological intervention
Stage 2 Partial integration (1950s-1980s)	Access to special education mainstreamed classes vocational education and rehabilitation services

	employment preparation transportation and communication general public facilities
Stage 3 Individual liberty and full citizenship (1990s-21st century)	Access to paid, community-based work medical and life insurance career-advancement opportunities postsecondary and higher education political power (state and national government legislative and executive positions) private business enterprise and control

The changes raise important questions for service providers: How much help should be given? To what extent should professionals intervene in an individual's life? How much individual decision-making is prudent? Finding answers is part of a lively effort to move education and human service agencies into Stage 3.

Self-determination Movement

Self-determination requires characteristics such as assertiveness, creativity, flexibility, self-esteem, and decisiveness. Persons with disabilities do not automatically practice self-determination upon reaching age 21. The characteristics are gained in developmental stages that begin in early childhood and continue throughout adult life.

Many communities are making efforts to transfer decision-making authority for educational and human services from large organizational units and professionals to consumers and their families. Some critics of these efforts warn that the transfer signals an attempt to reduce the government's responsibility in the social service arena and that the possibility of regression to earlier practices exists. Proponents argue that advocates should resist such negative thinking and "seize the many positive opportunities...to empower people and create inclusive communities (*Word from Washington*, 1991)."

To encourage the development of self-determination skills, educational processes for children and youth must shift from being strictly consumer-centered to being consumer-driven (with appropriate levels of support). Community agency personnel who promote self-determination support the following:

> **Empowerment and leadership**--National, state, and local policies must call for strong consumer and family involvement in planning, service delivery, evaluation, and advocacy and greater participation in decision-

making for early intervention, K-12 education, postsecondary education, adult services, and social and health services.

Choices and flexibility--Children with disabilities and their families deserve flexible support programs individualized to assess their needs. Such services are more cost-effective and efficient and avoid unnecessary and unwanted services.

Consumer-controlled housing--Consumers should have a major voice in designing and evaluating home-based supports that might be provided.

Full community participation--Children, youth, and adults with disabilities and special needs will advance beyond mere physical presence in schools and communities to enjoy all the community has to offer through participation in recreation, leisure, and civic activities.

Positive public education--The public's perception of and attitudes concerning people with special needs will improve.

Explicit training for self-determination and self-advocacy is essential if individuals with disabilities and their families are to have greater control over their lives.

Total Quality Management (TQM)

The principles of total quality management (using authority appropriately, communicating effectively, increasing productivity, developing standards, bringing about organizational change, etc.) have influenced education and human services as well as the business community. TQM increases emphasis on organizations' accountability for performing more efficiently and showing positive outcomes for the consumers. Service coordination can be a powerful vehicle for applying TQM principles.

Principles for Interdisciplinary, Interagency Service Coordination

Across the nation, educational agencies and human service programs are facing severe budget shortages. At the same time, many are faced with more challenging consumer populations. Unfortunately, in response, some agencies are attempting to exclude consumers. This practice directly contradicts the intent and spirit of recent laws and initiatives protecting citizens with disabilities.

Consumer-centered principles and practices in service coordination and service delivery can strengthen a community's resolve to develop an inclusive system of services. Service coordination experts recommend that when a change is being initiated in human services organizations, it should be accompanied by a redoubled effort to communicate program values and

ideology to ensure that cooperating professionals share a common understanding and value base. Following are brief definitions of 18 of the most common principles and values held by service coordinators (Cargonne, 1982; Kochhar, Leconte, & Ianacone, 1987; Kochhar, 1994).

Principle	Definition
Normalization	belief in integrating individuals to the extent possible into mainstream society
Developmental model	belief that services should be appropriate to the developmental stages/levels of the individuals
Advocacy/affirmative action	belief that services should make aggressive attempts to provide outreach to and improve access for individuals who have traditionally been under-represented in the consumer population
Quality assurance	belief that service coordinators should be active in ensuring continuing quality of services based on specified standards.
Accountability	belief that agencies should be held accountable for the quality and outcomes of their services
Lifetime continuity	belief that services should be available to support individuals with special needs throughout their lifespans so they can continue to grow, learn, adjust, and maximize their potentials
Inclusive family-based services	belief that the service system should respond to the needs of the whole family, not just to the individual
Comprehensive services	belief that through linkages services should address the full range of needs of individuals
Local access and local control	belief that services should be available to individuals in need within their local communities, rather than in larger regional centers, and that services should be managed and evaluated at the local level

Individualized service planning	belief that planning should occur at the individual level and that each consumer should have an individualized plan that includes goals, objectives, and services designated to meet the unique needs of the individual
Interdisciplinary team approach	belief that service planning should involve a team representative of the multiple disciplines and agencies to achieve combined professional expertise and resources
Individual strengths and needs focus	belief that service planning should focus on individual strengths and skills and needed service responses rather than on deficits
Single entry point	belief that consumers and their families need a facilitated, simplified access to the service system
Specialization	belief that service agencies should specialize in addressing specific needs of individuals, but they should coordinate the delivery of services to meet multiple needs
Self-sufficiency/self-determination	belief that learning and maturation are accelerated by education and support services that strengthen individual decision-making and support the right of the individual to make choices that affect his/her future and that the services should help the individual reduce dependence on the system
Community participation	belief that individuals with disabilities or special needs should be assisted in participating in the full range of opportunities, including education and human services, recreational and cultural activities, health and medical services, transportation means, social and political activities, etc.
Consumer centrality	belief that the individual should be the center of the service delivery system, that activities should serve his/her needs and interests, and that the consumer should participate in service planning and evaluation
Outcomes focus	belief that services should be directed at producing specific outcomes for consumers and that service providers should be explicit about the outcomes toward which they are working

Principles for Consumer-centered Service Coordination

The preceding list ended with emphasis on the consumer. Now you're asked to examine consumer-centered principles more closely. Following is a synthesis of the views offered by many experts in the educational, human services, and health service fields that describes ways to focus goals for service coordination activities (Erickson, 1991; Kagan, et al., 1991; Gerry & McWorter, 1990; Kochhar, 1987; Bachrach, 1986; Bradfield & Dame, 1982; Bruininks & Lakin, 1985; Callahan, 1981; Cargonne, 1984).

Principle	Discussion
Service coordination helps an individual achieve his/her potential.	Some individuals with special needs require short-term support in education and community settings and during transition from one setting to another. Others require extended support services or intermittent intensive support services. Service coordination activities are flexible and responsive to individual needs and assist the individual in achieving as much independence as possible in as many areas of functioning as he/she is assessed to have needs.
Service coordination activities result in improvements in the quality of life and learning environment of the individual.	Interdisciplinary and interagency personnel work together to strengthen the service system and the linkages among organizations and advocate for improvements in services on behalf of the individual. For example, efforts to improve K-12 education depend also on the improvement of health services, social service supports, and family supports. Conversely, efforts to improve the physical and emotional health of an individual depend upon improvements in health education. The system as a whole benefits from coordinated efforts to improve outcomes.
Service coordination promotes community integration.	Service coordination assists individuals to obtain services in the most integrated environments. Research shows that individuals make greater developmental, physical, and educational progress when services are received in integrated settings with nondisabled persons. Assistance to an individual is provided only at the level actually needed to promote independence and self-reliance.

Service coordination assists the individual to improve health and physical well-being.	A coordinated system of services addresses physical development, overall health improvement, and illness prevention for individuals. *Access* to education or support services does not simply mean enrollment but also the ability to benefit. An individual does not truly have access if he/she is in ill health and unable to participate fully. Developmental, educational, and support services cannot be effective unless the health and physical well-being of the individual participating in them is maximized.
Service coordination assures equitable access to a range of needed services.	Support services are available to individuals with all degrees of ability or disability. They serve those with the greatest need for support, minimize gaps in coverage, and assist individuals in enrolling and participating in community services. An important goal of service coordination is the development of a range of settings that meet the different needs of the individual. Priority is given to individuals who are at risk of failing to progress in integrated settings.
Service coordination reinforces the informal support network.	Service coordination activities strengthen self-help and support an informal network that includes the individual's parents, siblings, and extended family. Cooperating agencies recognize the informal support network is a key factor in the individual's ability to progress and adjust. Therefore, service coordination activities also address the support needs of the family. For example, health services to a preschooler also address the health and nutritional environment of the parents and siblings.
Service coordination promotes integration into community service delivery systems.	Natural environments are the preferred settings whenever possible. Service coordination activities link individuals with the range of community-based services such as mental health, public health, social services, legal, home health, employment, training, and others instead of creating additional services that duplicate those already available to the general public.
Service coordination evaluation methods focus on individual outcomes and service improvements.	Service coordination activities provide for self-evaluation of system performance, and measures are centered on individual outcomes in areas of services provided.

Roles of the Family in Service Coordination

Parents have been very powerful advocates in initiating services for children and adults with special needs over the past century. Parents have also stimulated major changes in education and human service systems nationally and locally. Many educators and human service professionals believe the participation of parents and other family members is the most crucial factor in an individual's potential to benefit from services.

Recent legislation establishing service coordination for children and families has resulted in an expansion of family-centered service coordination that is unique in law and in practice (Weil, et al., 1992). For example, the regulations under Part H of the Education of the Handicapped Act Amendments of 1986 and 1991 include the following:

> *The Secretary recognizes that parents (1) must be actively involved in making sure that their eligible children and other family members receive all of the services and protection that they are entitled to under this part and (2) are major decision-makers in deciding the extent to which they will participate in and receive services under this program* (54 *Federal Register*, 26331, 1989).

The regulations introduced the term *service coordination* in place of the more commonly used *case management* to steer away from the conventional idea that individuals and their families needed to be managed, handled, or controlled. The new terminology and requirements emphasize the choice and voluntary participation of the family and the responsibility of the service system to protect the rights of individuals and families.

The new language emphasizes two messages:

- There needs to be a parent–professional partnership with parent/family participation in service delivery and outcomes.
- The family unit as well as the individual should be given assistance and support from service agencies.

Several themes for participation of parents and families in service coordination have emerged:

Theme	Description
Parents and families as partners	Parents and families are partners with professionals in the service delivery process and must be viewed as collaborators, not service recipients. As parents and families have equal status with professionals in the team decision-making process, they accept shared responsibility for outcomes. Agencies should coordinate to develop special services to help parents understand their partner role and help them raise children with special needs.
Parents and families as team members in the individualized planning process	Parents and families need to be involved in the assessment of their children's needs and must participate with members of the interdisciplinary team in developing individualized service plans. They should also participate in family needs assessments in support of the individual service plans. They should be invited to participate in each annual planning meeting and in any change of placement or level of services decision. They should be invited into the service planning, policy development, and service evaluation processes and in the planning for training of service coordinators. They should also learn how to carry out and reinforce services in the home.
Parents and families as decision-makers	Parents and families cooperate and consult with professionals, but they are the lead decision-makers regarding the assessment and the services which are to be provided.
Parent and family training for advocacy	There should be training and resources to help family members advocate and coordinate services. Families need to be educated and empowered to acquire and to assist in the creation of inclusive services and supports (Nesbit, Covert, & Schuh, 1992). Parents/guardians should be members of the service intervention system and must be informed about available community and outreach services. Parents/guardians need to understand concepts such as self-determination, self-advocacy, IFSP, services coordination, transition, full inclusion, IEP, and least restrictive environment. They need to know the legal and human rights of their children. Local agencies should take responsibility for providing parent training programs and can link with university education programs to assist in developing parent training courses.

Parents and families as peer supports	Parents and families should be helped to provide basic support to one another to achieve satisfactory outcomes for their children. There is a need to organize parent support groups in which experienced parents of children with disabilities help newer parents by providing counseling and support on an as-needed basis.
Parents as transition team members	Parents should be involved in the process of their children's transitions. Transition coordinators can provide parent training seminars.
Resources and supports for parents	Funding of parent resource centers by local, state, or national sources must be ensured. One strategy is to merge early intervention support services with K-12 resource center supports. Another is to work with the state health and human services departments and mental health-mental retardation divisions to garner Medicaid waiver funds to support training efforts. In 27 states, there are family subsidies that allow parents to keep at home children with disabilities who might otherwise be institutionalized. In many states, Medicaid covers such costs as respite care.
Parents as service coordinators	People can experiment with having early intervention specialists and educators act as consultants, helping parents learn to assume coordination responsibilities. They might visit homes to provide training or counseling. Parents need to be educated about Social Security (SSI) provisions that provide services and tax deductions to support employment training, work trials, and post-secondary education for young people with disabilities.

Educators and human service professionals now understand the crucial role families play in helping individuals reach their potential. More current models of service coordination are family-focused, exemplified by service coordinator titles: home visitor, family advocate, family consultant, family service provider, family development specialist.

Though their titles and specific functions may differ, all family-centered coordinators are likely to use family needs assessments and create family service plans. They address needs for food, housing, parent literacy, vocational training, parenting skills, mental health services, and public benefit access.

Family-centered approaches are receiving attention in public schools as well as in human service agencies. Educational leaders realize their efforts to improve students' learning are integrally related to family circumstances. One reason for poor outcomes of school-to-work transition programs is the absence of family-focused approaches that promote student and family determination of transition goals and services (Gerry and McWorter, 1990). Some schools are offering parents special supports: basic academic skills classes, language classes, vocational skills training, and employment counseling.

Strategies for Facilitating Family Involvement

Merely calling for more family involvement isn't enough; strategies are needed to make it happen. The strategies must be based upon

- the belief in informed choice among service options by the individual and his/her family
- the principle that the service system needs to help individuals and their families use available community resources
- the belief that services are coordinated around the life of the individual and family, not around the needs of the service providers
- the recognition of the ability of the ordinary citizen to teach people skills and help them participate in community life (Mount & Zwernik, 1988)

Strategy	Description
Provide parent training and support	To increase parent involvement, hold seminars throughout the year, engage parents to train other parents, use concrete examples when talking about options, arrange visits to programs so parents can observe their sons/daughters, conduct parent-professional panel discussions, create parent support groups (Everson, Barcus, Moon, & Morton, 1987), and make all training available in convenient locations and at convenient times.

	Some service systems form a team of parents and professionals; together, they identify important issues and develop a systems change plan. Family leadership is a means of empowerment.
Use the individual's natural support system	Make use of natural support systems made up of family members, friends, neighbors, peer groups, and organizations such as churches, schools, unions, clubs. Social networks are essential in helping individuals and their families solve problems in daily life and get through crises. Folk support systems have a nourishing and stabilizing effect on individuals during times of change and challenge (Gerhard, Dorgan, & Miles, 1981). Not only do informal support networks help individuals survive by establishing and maintaining nurturing relationships and by rallying during moments of need, the supporters also become essential players in decision-making about needed services and programs.
Do personal futures planning	Many personal planning strategies rely on the involvement of families and the informal support networks. Futures planning is a long-term planning and problem-solving process guided by individual and family desires and needs. Personal futures planning, or circles of support planning, uses a personal profile, includes a planning meeting, and produces a futures plan document. The profile contains a record of the person's life, including important relationships, past events, preferences, dreams, barriers, and opportunities. The profile emphasizes individual gifts, skills, and capabilities. The planning meeting involves the individual, his/her family, and other key persons in his/her life. The meeting follows several steps to develop the plan: review the personal profile; review the environment, including events that are likely to affect the individual or family positively and negatively; create a desirable vision of the future; identify obstacles and opportunities; identify strategies and make commitments to take specific action steps to implement the vision; get started by prioritizing action steps and beginning to work on them; and identify needs for systems change, constraints of the service system, and obstacles to realizing the vision. Service coordinators can facilitate futures planning for consumers and their families, basing the process on three assumptions: the quality of everyday activities and relationships should be the focus of efforts on behalf of individuals with special needs; services are not enough--family relationships and friendships offer benefits that cannot be purchased at any price; no single person or service can or should do everything--persons are more dependent when they must rely on only one or two services to meet their needs (Nesbit, Covert, & Schuh, 1992). Personal futures planning complements the more organized procedures such as IEP planning and individualized family service planning.

Do transition planning	In the past, longer-range life planning typically did not begin until the individual was in adolescence and the parents began to think about the individual's separation from the family. Yet, from the very earliest identification of a disability, parents/guardians can be helped to begin thinking about life planning. Gaining autonomy and self-determination skills should begin in the earliest years. Transitions begin as children move from hospital to home, from home to day care, from day care to preschool, from preschool to elementary school, and then to middle school, high school, and postsecondary life. Each transition can be difficult, and the individual and/or family may need extra support. Parents are better advocates when they view the educational development of their children with the future in mind. A future-oriented view creates a more realistic and balanced perspective on options available and choices that need to be made as their children mature.
Reduce barriers to community services	Individual educational plans should include how the services provided will integrate into the various forms of the folk support system. Efforts should be made by service coordinators to eliminate barriers that prevent individuals and their families from accessing generic, community-based services (a range of services available to the general public, including health, recreational, social, housing, employment, and training services).
Communicate value of parent involvement	Throughout their children's development, parents need to hear that they are needed and valued as contributing members of planning teams. Means to that end are written materials distributed to parents, special parent support meetings or education seminars, opportunities for parent volunteer activities, and invitations to service planning meetings. Special attention is required as individuals enter service agencies for assistance because parents often feel their support is no longer needed. The transition from one service agency to another also calls for intensified communication with parents.

Support for Self-advocacy

A term becoming widely used, though not new, is *self-advocacy*, a social and political movement started by and for people with disabilities to enable them to speak for themselves on important issues such as housing, employment, legal rights, and personal relationships (Smith & Luckasson, 1992). Self-advocacy is related to self-determination, by which an

individual with a disability is directly involved in informed decision-making about his/her education, service program, and future.

A group of individuals with disabilities in Oregon initiated the self-advocacy movement in 1974; now, most states have self-advocacy groups and organizations such as the Association for Retarded Citizens and the Disability Coalition. These groups recognize that many people with disabilities have difficulty assuming control of their lives. The groups support development of self-determination and self-advocacy skills early in life to allow greater shared decision-making among individuals with disabilities, their families, and the professionals who work with them. With increased individual capacity to make informed choices and decisions comes greater responsibility and accountability for the outcomes of those decisions.

Directions in Interdisciplinary and Interagency Service Coordination for the 21st Century

All of the philosophies, theories, movements, and principles discussed in this chapter have influenced the future of service coordination. Coordination began as a way to integrate services and improve efficiency and lower costs; along with it came enduring and creative relationships among service sectors and their personnel. As collaboration continues, participants will focus on

- helping education, health, and human service agencies coordinate their services to improve early intervention and early childhood development to ensure children have a beginning in life that is physically, cognitively, and emotionally healthy

- helping educators and community agency specialists work together to ensure the K-12 gains made by children and youth are not lost in the transition to employment, postsecondary training, and independent living

- helping service providers engage families as partners in the development of individuals with disabilities

- helping communities organize long-term support systems for individuals as they adjust to the complexities of adult and family life

- helping service providers focus on outcomes, consumer benefits, and increased accountability

Service Coordination Provisions in Law

Most recent laws do not mandate service coordination but make recommendations that clearly encourage voluntary efforts at interdisciplinary, interagency collaboration and include language that is stronger than that in previous laws. National legislation includes two elements that guide the delivery of services at state and local levels: guidelines for how services are to be implemented, structured, and funded and statements about the principles and values that are expected to be reflected in program implementation and use of funds.

State and local regulations written to interpret the laws and guide implementation at the program level are often ambiguous. Clearly, though, they are aimed at improving the quality of services, increasing the participation of special populations in the full range of programs available, and ensuring coordination and collaboration among service sectors to improve access to and efficient delivery of services.

It is exciting to see many major public laws crafted in such a way that a durable framework is formed with the constitutional rights of access and inclusion interwoven. This framework forms a broad, far-reaching system of shared responsibility for including individuals with special needs in the full range of services.

National Laws and Service Coordination Provisions

National Law	Service Coordination Provisions
Individuals with Disabilities Education Act (IDEA, PL. 101-476, 1990)	Special education law requires the coordination of general and special education and many other related disciplines in individualized educational planning. The 1990 Amendments required transition services to prepare youth to move from secondary to postsecondary settings, employment, and adult life. The delivery of transition services requires coordination among special education, vocational rehabilitation, vocational education, related services, social work services, employment, and community services. The law also requires state and local agencies to improve the ability of professionals and parents to work with youth

	with disabilities; improve working relationships among educational, rehabilitation, private sector, and job training personnel; and create incentives to share expertise and resources.
Early Intervention for Infants, Toddlers, and Preschoolers (PL. 99-457, 1986; PL. 102-119, 1991)	This law requires comprehensive and coordinated services for infants, toddlers, and preschoolers from birth through age 5. Formal agreements between the state lead agency and other state-level agencies involved in early intervention programs are required to explain financial responsibility for services; develop procedures for resolving disputes between agencies; designate a lead agency to coordinate all available resources for early intervention services, including federal, state, local, and private sources. A service coordinator must be responsible for coordinating all services across agency lines for the benefit of children and their families.
Americans with Disabilities Act (ADA, PL. 101-336, 1990)	ADA is a major civil rights law that ends discrimination against persons with disabilities in private sector employment, public services, transportation, and telecommunications. General, special, and vocational educators and business and community service personnel need to collaborate to assist youth and adults to exercise their rights to access employment readiness services: preparation for interviews, knowledge about reasonable accommodation, and assistance with written job descriptions stating the essential functions of the job.
Higher Education Act Amendments (HEA, PL. 103-208, 1993)	Recent HEA Amendments are designed to increase the participation of individuals with disabilities in post-secondary education. The Act encourages partnerships between institutions of higher education and secondary schools serving low-income and disadvantaged students; encourages collaboration among business, labor organizations, community-based organizations, and other public and private organizations; seeks to increase college retention and graduation rates for low-income students and first-generation college students with disabilities; encourages collaboration among universities, colleges, schools, and other community agencies for outreach to students; promotes model programs that counsel students about college opportunities, financial aid, and student support services; and encourages collaboration of institutions of higher education with private and civic organizations to address problems of accessibility.

Carl D. Perkins Vocational and Applied Technology Education Act (PL. 101-392, 1990)	Perkins provides quality vocational and applied technology education services for youth. The law contains strong assurances for special populations to protect their access to quality vocational programs and services and requires a vocational education component in the IEP. The regulations require that supplementary services be provided to assure equal access for all special population students enrolled or planning to enroll in a recipient's entire vocational education program. Interdisciplinary collaboration among special, regular, and vocational educators is required to provide supplementary services necessary to ensure that youth with special needs succeed in vocational education. In addition, programs receiving funds must assist in fulfilling the transition service requirements of IDEA.
Job Training Reform Act (JTRA, PL. 102-367, 1993)	JTRA provides employment training opportunities for hard-to-serve youth and adults. The new law prescribes program performance standards to ensure that states make efforts to increase services and positive outcomes for hard-to-serve individuals. Youth and adult competency levels must be established based on factors such as entry-level skills and other hiring requirements. The Department of Labor is required to prescribe a system for variations in performance standards for special populations to be served, including Native Americans, migrant and seasonal workers, disabled veterans, older individuals, and offenders. These variances are in recognition that services to certain populations may take longer, cost more, and require alternative strategies.
Family Support Act (FSA, PL. 100-485, 1992)	The Act encourages the use of family-centered approaches to the problems of welfare dependency. The Act requires a comprehensive review, including family assessment and mobilization of supportive services (including child care) needed to remove barriers to parents' employment.
Public Health Service Act (PL. 102-321, 1991)	This law provides comprehensive and coordinated community mental health services to children and their families and funds to states for the development of systems of community care. The Act ensures that services are provided in a cooperative manner among various public systems and that each individual receives services through an individualized plan. Funds under the Act may be used to ensure collaboration through written agreements among mental health, education, juvenile justice, child welfare, and other agencies. The Act also ensures that there is a coordinator

	of services provided by the system and that there is an office serving as the entry point for individuals who need access to the system. The legislation requires that all relevant child-serving agencies be involved in the implementation of the local systems of care. Each state or locality must ensure that each child receiving services has a plan of care designating the responsibility of each agency.

State and Local Voluntary Guidelines for Service Coordination under the Individuals with Disabilities Education Act

Component	Guidelines
Disability definition	Autism and traumatic brain injury have been added to the definition of *disability*. The additions will require greater coordination of services, including medical, rehabilitation, and educational services to these individuals with complex physical and cognitive disabilities.
Secondary education and transition services	Transition services are included in the definition of special education services and are defined as "a coordinated set of activities designed with an outcome-oriented process." The law requires a statement of needed transition services in each individual's IEP (at 14 years of age if appropriate). The transition IEP requires that postsecondary agencies coordinate to determine needed services as the youth leaves secondary school. It mandates coordination among special education, vocational education, rehabilitation, and other community agencies. Five-year state grants are available to strengthen collaboration between state special education and state rehabilitation to improve statewide transition planning. The law also mandates efforts to increase availability, access, and quality of transition assistance; improve the ability of professionals and parents to work with youth with disabilities to promote successful transition; improve working relationships among educational, rehabilitation, private sector, and job training personnel; and create incentives to access and use expertise and resources of cooperating agencies.
Interagency agreements	Formal agreements between the state lead agency and other state-level agencies are required for early intervention and secondary transition services. They must include financial responsibility, procedures for resolving disputes between agencies, and additional components that are needed to ensure effective coordination.

Case management/ service coordination	The case manager/service coordinator is responsible for coordinating all services across agency lines, coordinating early intervention services and other services, and helping to develop state policies to ensure that case managers can effectively carry out case management functions and services on an interagency basis.
IEP contents	The IEP must include a statement of agency responsibilities for services to be included in a student's IEP. It is intended to address shared financial responsibility for providing transition services. The new law adds a subsection (d) in the content of the IEP: "A statement of the needed transition services for students beginning no later than age 16 and annually thereafter (and, if determined appropriate for an individual student, beginning at age 14, or younger)." The new requirement of agency responsibility is a direct encouragement of creative linkages among agencies to share resources and develop cooperative agreements.
Assistive technology services	This section addresses the need for assistive technology devices to be provided to maximize student benefits from education and training services. Technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. This requirement means that service agencies will have to coordinate with organizations that provide assistive technology and/or prepare professionals to understand assistive technology and know how to access it.
Related services and school social work services	The proposed definition of *rehabilitation counseling service* has been revised to change the meaning of *qualified rehabilitation counseling professional*. School social work services are included in related services and are defined as "mobilizers of school and community resources to enable the child to learn as effectively as possible in his/her educational program." The revision is a direct challenge to improve the cooperation between school programs and social service agencies.

Guidelines for Service Coordination for Infants and Toddlers under Part H of IDEA

Component	Guidelines
Purpose	This law calls for comprehensive and coordinated services for infants and toddlers from birth through age 2.

Interagency coordinating council	This council is made up of 15-25 representatives of state agencies providing early intervention services and parents who assist the lead agency to achieve the full participation, coordination, and cooperation of all appropriate public agencies in providing early intervention services.
Interagency agreements	Formal agreements between the state lead agency and other state-level agencies involved in early intervention programs are mandated. These agreements must designate financial responsibility for services, delineate procedures for resolving disputes between agencies, and include additional components that are needed to ensure effective coordination.
Financial responsibility	A state lead agency is required to identify and coordinate all available resources for early intervention services, including federal, state, local, and private sources. The state lead agency develops policies that are related to payment for services and are reflected in interagency agreements.
Service coordination	A service coordinator is responsible for coordinating all services across agency lines and for coordinating early intervention services and other services. State policies must be designed to ensure that service coordinators are able to carry out effective service coordination functions on an interagency basis.
Other coordination	Payment for covered services included in a child's IFSP or IEP cannot be restricted under Medicaid and EPSDT. Coordination with funding sources under Title V of the Social Security Act, under the Head Start Act, under the Elementary and Secondary Education Act of 1965 as amended, and under the Developmentally Disabled Assistance and Bill of Rights Act is required.
Transition	Flexibility allows funds to be used to support activities of an interagency coordinating council to train personnel to coordinate transition services from early intervention services under Part H to special education services under Part B.

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State and Local Voluntary Guidelines for Service Coordination under the Americans with Disabilities Act

Component	Guidelines
Purpose	ADA is a major civil rights law that ends discrimination against persons with disabilities in private sector employment, public services, transportation, and telecommunications. ADA will help increase access and open employment opportunities in the private sector. This Act underscores the need for many agencies to cooperate to ensure access for all individuals to the full range of education and human services, transportation, cultural and recreational facilities, and other services.
Job interviews	Vocational programs can and should teach individual students about their strengths and weaknesses to prepare them for potential job interviews. A student needs to be able to determine if he/she is "a qualified applicant with a disability" who can "satisfy the requisite skill, experience, education, and other job-related requirements of the employment position." Vocational and special educators, rehabilitation and job placement specialists, and employers will need to collaborate to address employment readiness issues.
Reasonable accommodation	According to the regulations of ADA, reasonable accommodations include modifications to a job application process that enable a qualified applicant with a disability to be considered for the position he/she desires and modifications to the work environment or to circumstances under which the work is customarily performed. Helping students determine their own reasonable accommodations for different jobs will be a critical part of their preparation for employment.
Testing issues	ADA prohibits tests for employment positions that are designed exclude individuals with disabilities because of their disabilities. This provision further emphasizes that individuals with disabilities are not to be excluded from jobs they can actually perform merely because a disability prevents them from taking a test or negatively influences the results of a test that is a prerequisite of the job.
Job descriptions	Vocational programs funded by Perkins can now prepare students by using descriptions of a specific job's *essential functions*, defined in the regulations as "fundamental job duties." All job descriptions must include fundamental job duties and be available to all potential applicants. This requirement will assist in preparing students for specific jobs and anticipate the need for reasonable accommodations.

Transition	Part of Perkins' assurances involves assisting students in fulfilling the transitional service requirements of the IDEA. Under the ADA, transition activities can include preparation for interviews, knowledge about reasonable accommodations, and assistance with written job descriptions stating the essential functions of the job. These activities help fulfill the transition requirements and are consistent with the intent of ADA to improve access to employment. Educators, employers, and community service personnel can collaborate to fund services under Perkins and IDEA.
Guidance and counseling	Perkins' assurances also include guidance and counseling services that are similar to those included under IDEA. For ADA to fulfill its purpose, students with disabilities in vocational programs must gain knowledge about job descriptions and reasonable accommodations before they interview for specific jobs. Special, general, and vocational educators must collaborate with guidance counselors to ensure appropriate guidance services.

State and Local Voluntary Guidelines for Service Coordination under the Higher Education Act

Component	Guidelines
Partnerships	New provisions of HEA are designed to increase participation of individuals with disabilities in postsecondary education. Title I encourages partnerships between institutions of higher education and secondary schools serving low-income and disadvantaged students. Such partnerships may include collaboration among businesses, labor organizations, community-based organizations, and other public or private organizations.
Student assistance	Title IV is aimed at increasing college retention and graduation rates for low-income students and first-generation college students with disabilities. Priority is placed on serving students with disabilities who also have low incomes. The priority challenges universities and colleges to collaborate with schools and other community agencies for outreach to students.
Model program	Chapter 4 of Title IV allows for grants for model programs that counsel students about college opportunities, financial aid, and student support services and encourages creative collaborations among colleges, universities, financial aid organizations, and support service agencies.

Educator recruitment, retention, and development	Title V is intended to provide assistance to the teaching force to improve professional skills, address the nation's teacher shortage, support recruitment of under-represented populations into the teaching force, and promote high-quality child development and early childhood education training.
Community service programs	Title XI provides incentives to academic institutions to enable them to work with private and civic organizations to address problems of accessibility of special needs individuals to institutions of higher education and to reduce attitudinal barriers that prevent full inclusion of individuals with disabilities within their communities.

State and Local Voluntary Guidelines for Service Coordination under the Carl D. Perkins Vocational and Applied Technology Education Act

Component	Guidelines
Special population assurances	Perkins provides quality vocational and applied technology education services to youth. The law contains language with strong assurances for special populations to protect their access to quality vocational programs and services. Perkins requires a vocational education component in the IEP, and it cross-references HEA assurances.
Supplementary services	The regulations require that supplementary services be provided to assure equal access for all special population students enrolled or planning to enroll in a recipient's entire vocational education program. Interdisciplinary collaboration among special, general, and vocational educators is required.
Full participation	The *Use of Funds* section requires each recipient to use Perkins' funds to improve vocational programs with "full participation of individuals who are members of special populations." This provision permits flexibility and reflects confidence that the local programs will be able to collaborate to provide the range of supplementary services most appropriate to the needs of special population students.

Vocational-technical education services and transition requirements	Perkins provides assurances that members of special populations will receive supplementary and other services necessary to succeed in vocational-technical education. Programs receiving funds also must assist in fulfilling the transition service requirements of IDEA. The law encourages coordination between special and vocational-technical education.
Special education	The special education administrator should assist in ensuring that changes in vocational education programs and services are implemented fairly and equitably and do not place disadvantages upon persons representing special populations. He/she should also be expected to work closely with the special populations representatives on the state council. The state special education sign-off for the special needs plan should ensure there is integration and connection in the plan and a clear relationship among the following features of the vocational education state and local plans as they affect special populations: results of the needs assessment, planned activities that will lead to program improvement, funds attached to each of those activities, proposed standards and measures for evaluating program performance, proposed monitoring procedures, evaluation procedures that will be used for overall program quality evaluation, and key personnel assigned to coordination and administration.

State and Local Voluntary Guidelines for Service Coordination under the Job Training Reform Act

Component	Guidelines
Purpose	JTRA provides employment training opportunities for hard-to-serve youth and adults. It establishes programs to prepare youth and adults facing serious barriers to employment for participation in the labor force.
Improved outcomes	The new law prescribes program performance standards to ensure that states make efforts to increase services and positive outcomes for hard-to-serve individuals. Youth and adult competency levels must be established based on factors such as entry-level skills and other hiring requirements.

Adjustments	The Department of Labor is required to prescribe a system for variations in performance standards for special populations to be served, including Native Americans, migrant and seasonal workers, disabled veterans, older individuals, and offenders. These variances are in recognition that services to certain populations may take longer, cost more, and require alternative strategies.

State and Local Voluntary Guidelines for Service Coordination under the Family Support Act

Component	Guidelines
Family participation	The law requires participation of the family in the development and implementation of the child's individual plan for services; information be provided to the family on the progress being made by the child; the family be provided assistance in establishing the child's eligibility for financial assistance and services under federal, state, or local programs, including mental health, education, and social services; and parents be involved in the evaluation of the effectiveness of these systems of care.
Interagency collaboration	The legislation requires all relevant child-serving agencies be involved in the implementation of the local system of care. Each state or locality must ensure that each child receiving services has a plan of care that designates the responsibility of each agency.

State and Local Voluntary Guidelines for Service Coordination under the Public Health Service Act

Component	Guidelines
Purpose	This Act provides comprehensive and coordinated community mental health services to children and their families.
Community care	The Act provides funds to states for the development of systems of community care for children, adolescents, and their families.

Service coordination	The Act ensures that services are provided in a cooperative manner among various public systems and that each individual receives services through an individualized plan. Funds under this Act may be used to ensure collaboration through written agreements among mental health, education, juvenile justice, child welfare, and other agencies. The Act also ensures that there is a coordinator of services provided by the system and that there is an office that serves as the entry point for individuals who need access to the system.

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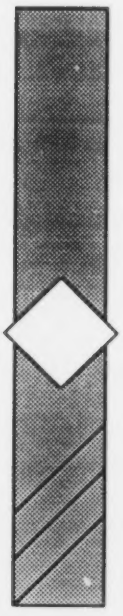

CHAPTER 2: The Defining of Interdisciplinary, Interagency Service Coordination

This chapter defines the essential components of service coordination and explores the role of the service coordinator. These definitions should provide a framework for understanding the complex relationships among people and organizations that are integral to the processes you are exploring.

Some Underpinnings

Today, service agencies, schools, parents, consumers, and others must collaborate to create support systems within the community. Such collaborations are often achieved through interagency partnerships. Far more than collections of agencies with a common purpose, interagency partnerships exist to create and implement *systemic strategies* for addressing the developmental, health, and educational needs of individuals with disabilities and their families.

In education, health, and human services, a *systematic strategy* involves developing goals, activities, and approaches to address human needs in a coordinated and organized way. The individual is viewed as having complex and interconnected needs that require coordinated responses from service agencies. *Service organizations* pool their resources to meet those needs in ways that will in turn improve the *service system* as a whole.

A *coordinated interagency service system* is both an ideal and a strategy. First, it is a sophisticated structure for responding to individuals with special needs--within their communities, in the most integrated settings possible, and in a manner that promotes individual decision-making.

It is also a strategy for mobilizing and organizing all of the appropriate resources to link the individual and his/her family with the service system. This strategy can achieve successful outcomes by ensuring continuity of services, overcoming the rigidity of the system, and preventing fragmentation, inaccessibility, and/or inappropriate use of services (adapted from the Joint Commission on Accreditation of Hospitals, 1991).

If you want to know whether you're working within a coordinated inter-agency service system, use these questions as a test:

- Are there activities, goals, and strategies designed to improve the availability of and access to services by individuals and groups?

- Are systemic strategies employed that are explicitly designed to improve education, health, and/or community services?

- Are local and statewide system change strategies being used to assist local education, health, and community service organizations to develop/strengthen interagency collaboration?

- Is consumer-centered goal-setting a shared value?

The basic elements of service coordination can improve both quality and efficiency wherever there is a need for multiple services provided through multiple agencies or through multiple disciplines. Just as there are many philosophies through which the principles of service coordination are being filtered, there are also many models in operation. What follows is a summary of the most common.

Models of Interdisciplinary, Interagency Service Coordination

Model	Key Features
State-level interagency planning	State interdisciplinary and interagency initiatives are sometimes responses to federal policies and sometimes emerge independently. They involve partnerships between one or more agencies to • assess statewide needs • identify funds to support local service coordination • advocate for target populations • ensure continuity of and access to services • provide training for service coordinators • engage in cooperative planning and policy development • reduce service duplication • develop and/or fund local interagency projects State governments and agencies play a pivotal role in stimulating and shaping local service coordination.

Local systems coordination	Service coordination activities have their greatest direct impact at the local level. Many local service systems are adapting the core services model for linking consumers with services. The interagency system defines essential core service coordination functions and then determines the agencies that will provide these services. Once identified, these agencies • conduct area-wide needs assessments • identify the service coordination functions required to address priorities the assessments revealed • clarify which agency(ies) will take the lead • assign specific functions to specific agencies • collaborate to identify and overcome service gaps and barriers, to increase the amount of service or the range of services, and/or to improve the quality of services
Family model	This model is evolving from a tradition of service coordination being provided by the family. In many cases, the consumer's family acts as service coordinator. Some service systems are providing families with information, training, and support groups to enable them to be better coordinators and more informed advocates.
Supportive care model	This model relies on the natural support structures in a community. Community members are matched with consumers to serve as their personal care workers. Varying versions are used in rural areas of the U.S. and in developing nations.
Volunteer model	Many agencies and service systems use volunteers to carry out service coordination activities. The volunteer model is similar to the supportive care model, but it has no paid workers. Volunteers provide the coordination services and are supervised by agency personnel.
Federal systems model	This model uses a variety of strategies that link the activities of several national health, education, and human service agencies. The purpose of federal-level interagency initiatives is to set an example or provide leadership to stimulate similar efforts at state and local levels. These initiatives establish linkages for distributing responsibilities for specific services or populations. They may include interagency planning, joint goal-setting, joint research/demonstrations, and shared financial and human resources.

State interagency planning model	State interdisciplinary and interagency initiatives sometimes are responses to federal initiatives or policies and sometimes emerge independently. The partnerships formed serve purposes such as these: • statewide needs assessments • funding support for local interagency service coordination • advocacy for target populations • continuity of services and access to the full range of services • professional development and training for service coordinators • cooperative planning and policy development • reduction of service duplication • joint development and funding of local interagency projects
Local systems coordination model	Many local systems are adapting the *core services* model for linking the consumer with services. Under this model, the interagency system defines the coordination functions it considers essential and then determines which agencies will provide these services. In turn, the agencies • conduct area-wide needs assessments and cooperative planning activities • identify requisite service coordination functions • clarify which agency(ies) is to take the lead in implementation
Comprehensive model	Within this model, service coordinators are involved in a variety of activities that affect service outcomes at the individual and interagency levels. It calls for a cadre of service coordinators who perform activities that affect consumers and the services system as a whole: • increasing service access to target groups • affecting service priorities and service distribution by acting as gatekeepers for access to services and by communicating consumer needs to administrators and other decision-makers • improving communication across agencies and disciplines by developing and engaging participants within the system in a common language for talking about services and service coordination • providing quality assurance by monitoring delivery of interdisciplinary and interagency services • helping participants engage in problem-solving by providing constructive intervention and trouble-shooting • assigning by agency(ies) specific service coordination functions • collaborating to identify and overcome service gaps and barriers, increase the amount/range of services, or improve the quality of existing services

The decision about what model to adopt must be based on the unique conditions of the system. Here are some key factors to be taken into account:

--the range of services available and the complexity of service needs
--the system's fiscal health
--the political climate and the style and quality of leadership
--demographics of the consumer population and the larger community
--the degree and rate of change within the service system
--the service philosophies in operation

Service Coordination--What Is It?

As you might expect from the number of models that have been developed, people have spent almost as much time defining the term as implementing it. Two definitions--one from the Joint Commission on Accreditation of Hospitals and the Accreditation Council for Services to Persons with Disabilities (1990) and the other from the Developmental Disabilities Act of 1984 (PL. 98-527)--are combined and expanded here to provide a shared starting place.

Definition--*Service coordination* is a process for linking the service system to the consumer and coordinating the various elements to achieve successful outcomes. This process includes eight essential functions:

- Information and referral
- Intake and screening
- Assessment and diagnosis
- Individual program planning and development
- Service coordination and linking
- Service monitoring and follow-along
- Individual and interagency advocacy
- Service evaluation and follow-up

As the definition implies, service coordination can be used to strengthen the linkages between individuals and service agencies (individual level) and also to improve the manner in which agencies collaborate to enhance services (interagency level).

At the individual level, the focus is on direct services to consumers and their families; at the interagency level, the focus is on availability of services and the provision of services. Service systems respond from three perspectives, each having its priorities within the coordination process.

- The perspective of service coordinators and consumers receiving services puts their focus on the needs of individuals. Service coordinators are concerned about ensuring continuity of services and advocating when there are service gaps and/or inefficiencies.

- Providers have a slightly different perspective. Their concern is primarily clinical, with a focus on providing services to target populations of given service programs and on cooperating with one another to establish a full range of service options and consumer pathways to access them.

- From the administrative perspective, the concern is for the availability of services to a range of populations at risk within the service area and a communication network sufficient to link all service elements, other elements of the broader human services system, and the consumer's immediate environment.

Service Coordination at the Individual Level

Service coordination activities help link consumers with appropriate services or agencies to achieve outcomes such as these:

--Improvements in consumer access to a needed service
--Changes in a child's developmental milestones as a result of services
--Better consumer access to assessment and diagnostic services
--Improved quality of life and a better learning environment for the consumer
--Improved community and community-based service integration
--Intensified focus on individual outcomes and service improvement on a consumer-by-consumer basis

Service Coordination at the Interagency Level

Many service coordination activities affect the system of services as a whole in positive ways, producing outcomes and improvements at the interagency level. At this level, the mission of coordination is to improve

the service system by increasing the synergy created by the interaction among its parts. Outcomes pursued might include

- multiple-agency projections of future needs for services
- development of new support services to help consumers enroll and remain in services
- increases in agencies' ability to expand services offered or the number of people served
- increased ability to serve new populations
- more sharing of resources among agencies for systemic improvements

A Closer Look at the Eight Basic Functions of Service Coordination

Differentiating between individual and interagency responsibilities is an important part of defining service coordination. A working knowledge of the eight functions subsumed within those categories is equally valuable.

The definitions that follow are synthesized from the study of a wide spectrum of service coordination programs in operation during the 1980s (Kochhar, 1987) and a less formal examination of more recent developments. Though the primary focus of the first six functions is on individual consumers and their families, in practice all of the eight functions include both individual and interagency components.

Function 1: Information and Referral

This function varies widely among interagency systems depending how those systems define the function:

> *very narrowly* as information-giving to the public and referral of consumers to agency services for which they are eligible
>
> *or*
>
> *broadly* to include extensive outreach activities, aggressive parent and community education and interagency case-finding activities to identify different groups of individuals needing services.

Whether at the **individual** or **interagency level**, the function usually includes activities such as identifying and conducting outreach, disseminating information about how to access services, developing one-stop shopping for consumers, coordinating diagnostic efforts, managing

referrals and follow-ups, and decreasing the lag between initial contact and entry into needed services.

Successful service coordination programs are designed to reach those in greatest need. When people learn about available services through an organized and coordinated public information and referral strategy, their service system is more likely to be perceived as accessible and to be valued by consumers and the rest of the community.

Aggressive and creative approaches to outreach are often needed. For example, homeless people with chronic health problems are more apt to accept service coordination assistance if such services are offered at nearby clothing or food distribution centers. Service information and coordination can best be marketed to juvenile offenders and their families by providing access at parole offices or in local community recreation centers.

Function 2: Intake and Screening

At the **individual level**, this function involves procedures to determine consumer eligibility for services and to match service requests with appropriate agencies. Specific activities often include measures like these: planning a reliable system data base on consumers served, developing eligibility and admission criteria, creating procedures to ensure that family needs are taken into account, making services accessible and user friendly, and obtaining and documenting informed consent.

At the **interagency level**, intake and screening can mean developing interagency data-collection and eligibility-determination processes. Joint data collection enhances efficiency and permits proactive responses to changing demands on the system.

Function 3: Assessment and Diagnosis

Needs assessment is a process by which information is collaboratively collected to address these questions:

> What is the current functioning (social, physical, intellectual, etc.) of the individual, and what are his/her strengths and needs?
>
> What features of the individual's environment support or inhibit improved functioning?

What goals and objectives for improved functioning should be included in the individual service plan, and what are the priorities?

What resources and services are necessary to accomplish these goals and objectives?

What procedures and schedules will be used to monitor progress toward these goals and objectives?

What outcome criteria will be used to evaluate results?

Diagnosis is a more specific term that refers to the process of identifying the presence of an illness, disease, or condition through examinations, tests, and assessment instruments. A diagnosis permits classification of conditions such as learning disabled, developmentally disabled, diabetic, or brain-injured to facilitate treatment and to establish eligibility for designated programs and services.

Assessment activities at the **individual level** include

- conducting comprehensive assessments of strengths and developmental needs in relevant functional domains
- reviewing assessments and renewing them periodically
- communicating and interpreting assessment information
- adapting assessment tools for individuals with disabilities and their families and eliminating cultural bias
- documenting assessment and diagnostic information
- making specific recommendations for interventions or service plans based on assessment information in all relevant functional domains

An important role of service coordinators is determining what the new goals and expectations will be for each consumer being served. What changes or outcomes can reasonably be expected within a year if the necessary services are provided? Once the goals are established, the specific gaps to be closed can be identified and services can be organized to help individuals and their families to close those gaps.

The following chart suggests the range of needs experienced by children, youth, and their families and the support required to close performance gaps; creating a similar summary for each target population served will further coordination efforts.

Possible Needs of Children, Youth, and Families and Support Services Required

Needs	Examples of Support Services Required
Developmental and functional needs	Training in functional and independent living, mobility, leisure skills, sexuality and family life skills, survival skills, money management skills, and family relationships
Physical, health, and nutritional needs	Medical services, drug treatments, and physician care; training in hygiene and nutrition; personal attendant services, assistive technology, special diets; neurological, medical, and health assessments
Cognitive and educational needs	Special education and remedial education; assistive technology, in-home teaching, educational consultation, guidance services, school-to-work transition services, academic and vocational assessments; training in speech, hearing, and English as a second language
Social, psychological, and mental health needs	Mental health and psychological services, behavior management services, crisis management and support, psychological assessments, and individual and family counseling
Social services needs	Juvenile and parole services, correctional education, legal services, advocacy services, residential planning services, guardianship assistance, and health insurance assistance

Needs assessment at the **individual level** should not be a one-time event but should be an ongoing process throughout the service relationship. The needs of individuals and cooperating agencies change over time. As consumers' needs change, so must the services and the goals and priorities those services are addressing.

At the **interagency level**, assessment involves some or all of the following:

- Defining the range of local services available in the existing system as a basis for identifying the existing foundation for a service coordination initiative

- Identifying service gaps
- Determining the level of readiness of individual disciplines or cooperating agencies to form a collaboration for meaningful changes in the service environment
- Determining the expertise and resources each discipline or agency brings to the partnership
- Assessing the needs of cooperating organizations

A thorough needs assessment can provide important information for determining how prepared each agency is to perform the eight core functions. Ongoing needs assessment can help the system keep pace with changes within agencies and within the service environment.

Function 4: Individual Program Planning and Development

The development of comprehensive service plans is an essential function of service coordination. At the **individual level**, comprehensive written individual service plans are essential for consumers and families who enroll in service programs because they stand as service agreements between consumers and service providers.

A service plan documents the planned activities and responsibilities of the consumer, service providers, family members, and others involved in setting and meeting plan goals. It also indicates the criteria by which all parties will determine whether services have been delivered and whether goals have been achieved.

There should be few professionals involved with service coordination who are not familiar with the components of an individual service plan. The following list serves as a quick review:

Components of an Individual Service Plan*

1. Date of entry into services and date of planning meeting.
2. Consumer identification (name, date of birth, address, sex, etc.).
3. Assistance needed to establish eligibility for services or to make application for services.
4. Names of service coordinator or program advocate and parents/guardians.
5. Names of individuals and agencies represented in plan development or review.
6. Summary of assessments and observations indicating consumer's strengths and needs.
7. Services the consumer and family are receiving.
8. Persons/agencies providing services.
9. Short- and long-range goals for the services and the priorities to be addressed.
10. Vocational-technical training and employment assistance objectives.
11. Strategies for service delivery and identification of persons or agencies to which the consumer and/or his family may be referred.
12. Service coordination supports needed and methods of monitoring receipt of services.
13. Special supports needed by the consumer to participate (transportation, assistive devices, financial help, etc.).
14. Criteria for evaluation of services built from explicitly stated and measurable outcomes.
15. Expected (realistic) dates of completion for each service to be delivered.
16. Potential barriers to accessing recommended services (eligibility criteria, admissions procedures, fees, attitudes, etc.).
17. Support needed to exit from services and to transition to other service providers or programs (as needed).
18. Signatures of all participants in the planning meeting, including the consumer.

**Synthesized from a review of many individual service plans from several states and localities.*

Program planning also occurs at the **interagency level** and often results in the development of an *interagency cooperative agreement.* Such agreements usually include these components:

- The shared mission of those participating in the agreement
- The resources that are to support the interagency partnership
- The activities the interagency partnership is to undertake
- A time frame for interagency activities

Because there must be unanimous commitment to its mission if an interagency partnership is to succeed, the mission statement itself deserves special attention. Effective statements tend to include these elements:

- A statement of context (often telling how the cooperative arrangement differs from or expands what has been in place before)
- The authority for the cooperative relationships
- A general statement of purpose and expected outcomes (rationale)

You'll learn more about cooperative agreements in Chapter 3. For now, you need to understand that drafting a first-time agreement is only the first step. Agreements, like service plans, must be reviewed and revised periodically if they're to remain effective.

Function 5: Service Coordination and Linking

At the **individual level**, service linking means identifying appropriate agencies, disciplines, and/or individuals to deliver needed services. For families of at-risk infants, it means providing a central contact who can help locate and link the family with services they and their infants need. For individuals with chronic health needs, it means providing information and linking with health clinics, physician services, and providers of in-home adaptive equipment. For secondary students leaving school, it means providing special services to achieve desired postsecondary placement.

Here are some more possibilities:

- Designating a service coordinator for each individual or family
- Contacting needed services within an agency's catchment area or beyond it
- Arranging for consumer and family visits to the service organization or program
- Arranging special services or supports for consumers and families who are moving from one service agency to another or exiting the service system

- Tracking changes in service placements or movement within service agencies
- Documenting support services used by consumers and/or families
- Documenting referrals to other agencies for assessments or additional services

At the **interagency level**, linking means sharing resources for interagency service coordination. Shared resources include financial, human, and material resources that belong to cooperating agencies and can be dedicated to service coordination activities as defined by the cooperative agreement. Linking activities can prevent duplication of services, thereby controlling costs and improving the quality of service to consumers.

There are other advantages. Because linking joins professionals from multiple disciplines, it creates a cross-fertilization of ideas that can lead to more satisfied service providers and more creative solutions to complex problems.

Function 6: Service Monitoring and Follow-along

At the **individual level**, the purposes of monitoring are to evaluate the consumer's progress to ensure that the individual is receiving prescribed services and to verify that those services are still appropriate for the consumer. The service coordinator must maintain ongoing contact with consumers and the agencies providing service--an advantage because it lets the coordinator understand services from the consumers' and the providers' perspectives.

Service monitoring activities may include

- maintaining a chronology of services received by each consumer and family and reporting any rationale for the absence of prescribed services
- documenting consumers' progress toward their goals
- documenting modifications in the service plan
- documenting efforts to close service gaps through interagency outreach efforts

- documenting barriers to service access

- maintaining continuity in service coordination

Service monitoring at the **interagency level** means observing the delivery of services of cooperating agencies and contracted service providers, ensuring that services are reaching intended populations, are being delivered on schedule and in keeping with relevant regulatory and ethical guidelines, and are meeting quality standards.

Monitoring activities at this level might include

- documenting performance of cooperating agencies and contracted service providers in terms of interagency goals, objectives, and timetables

- collecting information from consumers and their families about how they perceive the quality, appropriateness, and accessibility of services

- examining and improving interagency policies related to eligibility and termination criteria and policies governing supports for participation in the service program

- projecting needs for service monitoring in cooperation with other agencies

Follow-along is the relational aspect of monitoring and humanizes service at both interagency and individual levels. At the **interagency level**, follow-along activities include efforts to facilitate smooth working relationships among agencies in the day-to-day implementation of the cooperative agreement. At the **individual level**, it includes efforts of the service coordinator to provide emotional support, to foster relationships of trust with consumers, and to maintain close contact and communication with families.

Here are just some of the activities you might expect to see as part of the follow-along function at the **individual level**:

- home visits
- school and work-site visits
- informal counseling with families
- frequent face-to-face contacts with consumers and families
- crisis intervention

Function 7: Individual and Interagency Advocacy

At the **individual level**, advocacy can mean advocating on behalf of a consumer or family member(s) for services, or it can mean assisting those individuals to advocate on their own behalf. For many practitioners, individual advocacy has come to mean ensuring that service agencies promote self-determination and informed decision-making by consumers and their families.

Self-determination is the act of making independent choices about personal goals and directions based on accurate information about one's own strengths and needs and available options (Racino, 1992). Self-determination is best nurtured in an environment that promotes and facilitates personal decision-making. As the following summary shows, advocacy can range from advocating for consumers to helping consumers advocate for themselves.

Individual Advocacy Activities:
Two Poles of a Continuum

Advocating on an Individual's Behalf	Assisting with Self-advocacy
• assisting the consumer to receive all the benefits to which s/he is entitled	• assisting the consumer to request information about benefits to which s/he is entitled and to choose among them
• intervening to ensure that human rights and due process procedures are protected	• providing information about human rights and due process procedures to the consumer and/or family
• helping the individual gain access to a service from which s/he has been excluded	• offering strategies to gain access to a service from which the consumer has been excluded
• negotiating to gain a consumer admission to a program	• offering strategies, information, or coaching to help a consumer gain admission to a program
• negotiating for special support services or accommodations that will enable a consumer to participate in a service	• offering strategies, information, or coaching to enable a consumer to negotiate for special supports or accommodations that will permit his/her participation in a service
• educating the family and offering encouragement that will allow a consumer to participate in a service s/he fears	

• intervening with a potential employer to facilitate hiring	• coaching the consumer to assess his/her own job skills and training needs to help him/her gain appropriate employment

Interagency advocacy means advocating in similar ways, but doing so on behalf of whole groups of individuals. The following chart gives you some examples of such activities.

Illustrative Interagency Advocacy Activities

- developing interagency understanding of the needs of groups of individuals with special needs
- addressing multicultural and multilingual issues to negotiate the development of special supports or accommodations
- identifying and targeting those consumers in the greatest need of services
- communicating service barriers and service gaps to decision-makers
- communicating and protecting human rights and due process procedures for consumer groups
- promoting an emphasis on self-determination and informed decision-making for consumers and their families
- linking consumers and families with legal advocacy services
- working with local agencies to help them meet legal requirements
- providing leadership to improve intra-agency, interagency, and community attitudes about consumers and their families
- increasing supports available in transitions between services or to more integrated settings
- reinforcing the informal support network

As local agencies respond to new requirements for service coordination, advocacy can help build a shared capacity to meet the multiple needs of consumers and their families by reducing resistance to interdisciplinary and interagency coordination.

Consumer advocacy at the interagency level can also reduce the conflicts of interest that frustrate so many practicing service coordinators. If the focus of all organizations and individuals involved is consistently on consumers and

their needs, interagency turf-protecting and procedural rigidity should be more readily rejected as counterproductive.

Function 8: Service Evaluation and Follow-up

Although evaluation may be a final step in assessing the value of services to consumers, it is always the first step in their deliberate improvement.

Evaluation is a process by which information is collected about programs, services, or the service partnership to find out how powerful their positive effects are, to determine whether goals are being achieved, and to make decisions about the future. Evaluation is useful only when the information it generates contributes to sound decision-making.

It helps to think of evaluation as a strategy for measuring how well service agency partners are accomplishing the goals set in their cooperative agreements (**interagency level**) and to what extent consumers and families are benefiting from the services and resources provided (**individual level**). These are the kinds of questions evaluation as part of the service coordination process should address:

- How can it be determined whether the services are helping consumers and their families?
- What can be done to improve the interagency partnership to increase the benefits of services?
- How do the service beneficiaries judge the quality, accessibility, and appropriateness of the services?
- To what degree are the interagency partners meeting their cooperative agreement goals?

A coordinated interagency system should combine individual and interagency service evaluation activities to measure effectiveness and make decisions. One of the most important decisions to be made is whether service coordination is justifying the resources being invested. How this question is answered and who answers it will determine the level of continuing commitment.

Follow-up activities are those that track the path or disposition of consumers once they have exited a given program, service agency, or service system. They attempt to answer questions such as the following:

- What happens to consumers once they leave the service agency or program?
- Do they return for additional services, and are they more likely to access services on their own or to rely on others?
- Do consumers experience long-term benefits in terms of their quality of life as a result of having received services?
- Are there changes in perceptions of the quality and appropriateness of services after consumers have been away from them for awhile?
- What do long-term outcomes reveal about changes needed in the program, agency, or system?

Follow-up activities are important to the evaluation process because they help determine the long-term durability of benefits gained and/or progress achieved by consumers while services were being received. Activities related to service evaluation and follow-up at the **individual level** include

- conducting formal consumer and family surveys to obtain perceptions about the quality, accessibility, and appropriateness of services over time

  --evaluating individualized planning for consumers and their families

  --evaluating communication between consumers and their service coordinator

- interviewing former consumers to determine their satisfaction with services over time
- contacting former consumers to determine whether additional services are needed
- contacting individuals who have dropped out of services to assess attitudes and determine willingness to re-engage

Activities related to service evaluation and follow-up at the **interagency level** include

- evaluating interagency agreements and policies
- evaluating support services during transitions
- evaluating the effectiveness of interagency coordination functions
- evaluating follow-up activities for consumers as they leave service agencies and programs
- evaluating individualized planning procedures and consumer participation
- evaluating communication among agencies
- assessing agencies' use of evaluation information for service improvement

Chapter 5 contains an in-depth discussion of service coordination evaluation for service improvement.

The Service Coordinator Role

In reading these introductory chapters, you've seen dozens of references to service coordinators and their responsibilities within the coordination process. You already know the service coordinator is designated as a key link among agency partners and between consumers and services. If you've been waiting for a lock-step definition of the role that applies precisely within all service systems, you're in for a disappointment. The roles coordinators play within interagency partnerships can and should vary greatly in terms of the

- specific coordination functions performed
- kinds and amount of consumer and family contact
- primary goals to be met
- scope of responsibility and authority
- degree to which functions are attached to another role (teacher, counselor, administrator, nurse, therapist)
- evaluation criteria to be met

There is no one right way to craft the role of service coordinator; what matters is that service coordination functions are appropriate for and responsive to the needs of the consumer groups being served. There are, however, some reassuring constants.

What It Takes to Be a Service Coordinator

Service coordinators should be recognized as unique members of the particular agencies or groups of agencies for which they work. What makes them unique are the many hats they're expected to wear: assessment specialist, counselor, problem-solver, human resource developer, administrator, supervisor, evaluator, diplomat, coordinator, resource person, and public relations agent--just to name a few.

Meeting so many expectations calls for some specific abilities. A review of the literature and current service coordination programs shows service coordinators need to be proficient in twelve areas of competency (knowledge, skills, and attitudes):

1. Information and Referral

Service coordinators need to recognize community networks and know how to use them to inform the community about interagency planning and service coordination. They need to understand agency networks and be able to use them to reach target populations and to facilitate referral arrangements.

2. Intake and Screening

Service coordinators need to understand the strategies and procedures for bringing consumers into the system. They also need to know the basics of consumer screening to determine eligibility for relevant programs and services.

3. Assessment and Diagnosis

Service coordinators must have knowledge of the special needs populations in their community, region, and/or state. They must be familiar with applicable assessment tools and techniques and be able to select and use assessment procedures appropriate to the needs of consumers and their families.

4. Individual Program Planning and Development

Service coordinators need strong organizational skills and a talent for writing. They must be able to lead others in developing plans for individuals and groups, structure group activities, and assess group dynamics. They often are given final responsibility for group documents and for much of the required correspondence.

5. Service Coordination and Linking

Coordinators have to know the service agencies they're to be involved with--their missions, their organization structure, and the populations they serve. They need some knowledge of the pressures agencies are facing as they undergo restructuring in a tight economy. They need to have a working knowledge of several service coordination models, particularly those that are family-centered.

Coordinators must be familiar with various aspects of service-linking at individual and interagency levels, including referrals, visitation and meeting arrangements, negotiation of support services, and procurement of assistive technology. Because they are almost always responsible for fostering collaboration and initiating agreements, they need to have mastered strategies for running successful meetings and facilitating group problem-solving.

6. Service Monitoring and Follow-along

Service coordinators need to be able to apply strategies and tools for monitoring delivery of services to consumers and their families. Specifics include gleaning helpful information from home visits, case conferences, and interdisciplinary planning teams as well as tracking funding arrangements, accessing computerized information systems, and reviewing individual recordkeeping procedures.

7. Individual and Interagency Advocacy

Whether working at the state, local interagency, or single agency level, service coordinators must know how to get people to think productively about new service relationships. They must be able to communicate the benefits of service coordination in terms of efficiency and improved outcomes for consumers and their families. They must be able to keep the focus on those they serve.

They need to know and be able to make understandable the laws and regulations affecting service coordination at their state and local levels. They should also be familiar with national laws that protect the rights of special populations and their families to access services and funds. They need an understanding of the philosophies that are the foundation for effective service coordination, and they need to be good advocates.

8. Service Evaluation and Follow-up

Service coordinators should be familiar with the basic concepts of evaluation and--whether required to do so or not--be able to conduct consumer follow-up activities. Coordinators will benefit from being able to conduct organizational evaluation and follow-up as well.

9. Family-centeredness

Service coordination was invented to improve services to consumers and their families, a goal that requires family-centered approaches to service delivery. Coordinators need a knowledge of family dynamics, family systems theory, and family development as well as awareness of available family-related support services. Facilitating family participation in decision-making about services and goals requires skills in assessing family needs and problems.

10. Personal Development

Service coordinators are people first, and they must be people others respect and trust. They should be self-confident, persuasive, and determined to promote service coordination. They need to be able to make others feel welcome and needed, and they must be effective public speakers. They must be able to work independently; they need to be patient and persistent in the face of opposition. They must be able to set realistic expectations for themselves and their position--service coordination development usually comes in incremental steps along a rocky path.

11. Human and Social Sensitivity

Communication begins with finding common ground. Coordinators must be able to acknowledge the needs and concerns of cooperating agencies and consumer groups. Such acknowledgments can come only from recognizing and valuing differences.

12. Budget Management

In some interagency systems, service coordinators have direct control of funds for purchasing services. In many, they are expected to assist with fiscal planning and accountability. Mastery of basic budgeting skills, familiarity with accounting software, and an understanding of the political influences at play are becoming increasingly significant proficiencies.

By now you're saying, "Well, good luck finding someone who can do all of this!" Your skepticism is well-founded; it is sometimes impossible to find one person with proficiency in all twelve areas--especially someone who isn't already a wealthy CEO of some large corporation. There are two alternatives: selecting a team of two or three whose members collectively have the requisite skills or choosing someone who has many of the skills and is willing to master the rest. No matter how the position of service coordinator is filled or who fills it, inservice training should be an ongoing part of the service coordination support system.

What Service Coordinators are NOT

Service coordinators are not ad hoc troubleshooters nor are they politicians running for election. They need to be allowed to concentrate on duties directly related to service coordination and interagency collaboration. Always their first responsibility is to enhance service to consumers and families.

Job Descriptions for Service Coordinators

Coordinators can be misused and abused without the protection and accountability a clear job description provides. Job descriptions should be individualized to fit the situation and the people involved. The two examples that follow will give you a rough framework for assessing other descriptions you may encounter.

Sample Job Description #1
Service Coordinator-- Social Services Agency*

Qualifications Bachelor's degree in human services and one year of relevant experience

Role The Service Coordinator I position is a direct service provider and an information and referral agent for individuals needing services from the agency. The position is supervised by the Agency Director.

Functions

Identifies eligible individuals Visits the individuals referred to the agency by the courts, community agencies, police, mental health clinics, etc. and develops case histories.

Determines needs Conducts consumer and family needs assessments, develops social histories, collects additional assessment information from others who have relevant knowledge about the consumer.

Determines resources Locates and engages resources to meet consumer and family needs through contract arrangements with public and private provider agencies/ professionals within and beyond the catchment area.

Develops individual service plans Participates in team meetings, takes final responsibility for development of the plan document, which includes goals, financial aid needs, referrals, additional assessments needed, services to be provided, service priorities, contact schedules, activities schedules, persons responsible for services, and achievement criteria for services.

Develops and maintains individual records Maintains log of service coordination activities, including appointments and visits, services contracted, service barriers identified and addressed, contact notes, changes in service plans, and any other relevant information.

Advocates and follows along Assists the consumer in making service appointments, locates potential housing, assists family in accessing needed services, intervenes in court actions, assists in admission to services, counsels family, assists with placements. Provides/procures transportation and conducts outreach home visits as needed.

Engages in administrative/professional development Participates in inservice training and workshops, staff meetings, briefings by resource agencies, and service evaluation activities.

**A composite drawn from multiple job descriptions*

Sample Job Description #2
Service Coordinator--Early Intervention*

Qualifications Master's degree in early childhood education or early intervention or other relevant human service area and one year of relevant experience OR bachelor's degree and two years of relevant experience.

Role The Service Coordinator II position is an interagency liaison and supervisor for direct service coordinators for the community's infants and toddlers. The position is supervised by the Program Director of Early Intervention Community Programs, Department of Health.

Functions

Supervises direct service coordinators Supervises a team of five early intervention service coordinators who conduct outreach to families of at-risk children, do assessments, conduct home visits, manage information dissemination and referral, facilitate development of individual family service plans, and conduct monitoring and follow-up.

Evaluates early intervention service coordination activities Conducts evaluation and quality assurance activities to assess services. Evaluation includes record reviews, interviews with consumers, interviews with service providers, interviews with service coordinators, and review of follow-up reports. Writes evaluation summaries for the Director.

Determines needs Conducts area-wide needs assessments and family needs assessments and writes assessment reports for the Director. Presents assessment and evaluation summaries to the Interdisciplinary Board.

Determines resources and links agencies Seeks out resource providers and invites agencies to join the early intervention planning consortium, which includes educational agencies, family services, diagnostic and assessment centers, public health services, social service agencies, parent support groups, Medicaid and other insurance agencies, substance abuse services, allied health agencies, mental health services, and others. Identifies and pursues resources needed to meet the needs identified in the area-wide assessments through contract arrangements with public or private provider agencies/ professionals within and beyond the catchment area.

Develops area service development plans Prepares annual service development plans, including schedule of interdisciplinary planning team meetings and goals for interagency collaboration; reviews and revises annual interagency plan, including goals and objectives; participates in budget development.

Engages in administrative and professional development Participates in inservice training, workshops, and administrative meetings.

**A composite drawn from multiple job descriptions*

Chapter 3: The Planning and Managing of Interagency Service Coordination

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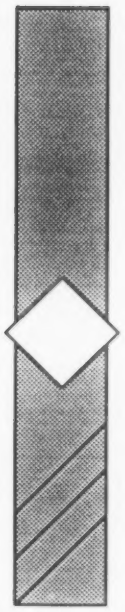

CHAPTER 3: The Planning and Managing of Interagency Service Coordination

A New Look at the Role of Interagency Service Coordination

Traditionally, interagency service coordination has been viewed as a management tool, an extension of agency administration. For example, service coordinators in some agencies develop service files, conduct file audits, collect data, and perform a variety of other administrative tasks. Though these are important tasks, interagency service coordination activities should be **person-centered** rather than procedural.

Service coordination must be viewed as an intervention, **a planned effort**, designed to produce intended outcomes for a target population. This attention to outcomes requires changes in the methods used to define and measure the effectiveness of interagency service coordination. First, the intended outcomes must be clearly specified. Then, interagency resources must be focused to pursue these outcomes. Finally, measuring benefits for consumers must be central to evaluating interagency performance.

Planned Change as a Management Practice at the State and Local Levels

There are many forces in service systems that affect the emergence of interagency teams and the durability of the change process. Innovation can decay in a short time if the environmental factors that support change are not identified and established as the basis of the interagency planning process. *Strategic planning* is essential to the formation and implementation of multi-agency partnerships.

> Definition--*Strategic planning* is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it (Bryson, 1988, p. 5).

Strategic planning helps people identify the broad aspects of the service environment, including political, economic, professional, and social influences. It also helps them understand how different service sectors can interact to improve service quality and access for consumers--a shared mission of all.

Circle of Commitment

A wide range of resources, both human and material, must be invested in an interdisciplinary, interagency effort to improve services and outcomes for consumers and their families. The circle is made up of six commitments:

- **Human**--Key stakeholders, staffs, and advisors in the interagency partnership
- **Value**--Shared beliefs for the development of consumers and their families
- **Financial**--Material resources invested by cooperating agencies
- **Action**--Shared mission, cooperative agreement, and common goals for the interagency partnership
- **Outcome**--Shared expectations for those served by the interagency partnership
- **Renewal**--Shared long-term plan to review the course of the interagency partnership, celebrate unique contributions of each agency, and renew commitments (Kochhar &Erickson, 1993)

Once commitments are made, those dedicated to achieving dynamic, consumer-responsive service coordination need practical guides.

Ten Steps for Developing and Implementing Service Coordination

These steps

- can be initiated by a single service sector or by many sectors
- are relevant for service systems with underdeveloped interagency collaborative relationships or with advanced relationships
- can form the basis for the design of evaluation of interagency relationships and outcomes

The steps reflect the experiences of collaborating agencies across the nation and are offered as guideposts for developing interagency action plans. Because a collaborative system must be flexible, the steps provide a menu of options, not a fixed model.

Step One--inform the community

Step Two--conduct preplanning assessment

Step Three--assess interdisciplinary, interagency needs

Step Four--identify shared resources

Step Five--establish shared mission

Step Six--design cooperative agreement

Step Seven--define management structure

Step Eight--develop adoption plan

Step Nine--create problem-solving strategies

Step Ten--evaluate for improvement

Step One--inform the community

Under current laws, state and local educational agencies are required to improve working relationships among consumers and their families and personnel in community agencies concerned with early intervention, education, employment, and rehabilitation of children and youth. (Specific interagency coordination provisions in special education legislation are detailed in Chapter 1.)

Improved working relationships call for shared information and a sense of cooperation. The planning team therefore begins the process of interagency collaboration by conducting activities to inform the community about intentions to coordinate the service delivery system. The activities should stress consumer needs and the benefits of coordination.

Consider the community members who might be involved:

- Parents*
- Consumers
- Educators
- School administrators
- Related support services personnel
- School board members
- Education-business liaisons
- Public and private health services personnel
- Rehabilitation personnel
- Social services personnel
- Adult and community-based services personnel
- Employers
- Job trainers
- Probation officers
- Advocates
- Police
- Recreation and leisure services providers
- College and university representatives
- Religious group leaders
- Local and state politicians

***Emphasize the parental role** as you inform the community about initiatives for interagency collaboration. Seek to enlist parents as advisors and planners. If they support the effort, parents can be the best champions for change. After all, they and their children with special needs will benefit the most from service coordination. To reach parents, target PTAs and support groups.

Realize, though, that champions for interagency collaboration can emerge from any community sector once the value of the initiative is communicated.

Reach parent, student, and consumer organizations	Make presentations to PTAs, parent/consumer advocacy groups, and student organizations about the plans for service coordination. Beyond informing, solicit their input as to what roles they can play in the development of the collaboration.
Talk to educational leaders	Superintendents and principals should be among the earliest to be informed of the effort and helped to see how the initiative will aid them in achieving their educational goals and objectives for students.
Enlist the support of teachers and educational associations	Help teachers understand the potential benefits of the collaboration for themselves and the students with whom they work. Ask AEAs and LEAs to go on record as supporting the initiative.

Meet with staff and directors of community and adult service agencies	Because their support is vital to an interagency services coordination initiative, agency personnel need to know about an intent to collaborate, the process for forming the collaborative arrangement, and the importance of their individual and agency contributions.
Make employers part of the process	Make presentations at Chamber of Commerce meetings, private industry council gatherings, and supported employment conferences.
Get on the agendas of community organization meetings	Let community leaders know what interagency service coordination is all about and show them the societal benefits of collaboration.
Develop links with local colleges or universities	Help postsecondary educators understand the collaborative role they can play; their institutions will receive many students and prepare many of the key stakeholders who will be partners in the agency service coordination effort.

Regardless of the target audience, the following strategies are applicable:

Utilize local newsletters and newspapers	Write editorials and feature articles about the initiative.
Create brochures and packets	Within the brochures, explain the mission and benefits of interagency collaboration. Include information packets in the local budget documents that are distributed to educational and community agency planning boards. Design an interagency logo to identify the key partners in the initiative and promote the interagency partnership.
Utilize annual reports of cooperating agencies	Include descriptions of interagency initiatives and plans in the annual reports.
Conduct highly visible brainstorming meetings	The sessions can be held for a single target audience and/or for audiences made up of representatives of disparate groups.
Write concept papers and rationale statements	Help each potential cooperating agency/organization understand the collaborative endeavor, its mission, and the accompanying goals and objectives.

Become part of local education reform seminars	Volunteer to discuss the interagency initiative whenever a reform effort is underway.
Hold special seminars	Provide interagency service coordination training for members from a variety of agencies and organizations.

Strategic Meetings for Putting Together Interagency Teams

A *strategic meeting* is one in which people are brought together in combinations that are likely to bring about change--new perceptions and new relationships. Remember, interagency service coordination depends upon **successful relationships** among people in the cooperating agencies.

Another strategy for informing community groups about an interagency partnership initiative is bringing together representatives from each of the organizations that are likely to be working together. Try starting on a smaller scale—joining teachers with employers and parents or joining early intervention specialists with public health and human services personnel.

Use the following questions to help you determine the best membership for a strategic meeting:

- Who among all of the stakeholders can best help in defining goals and making decisions?
- What combination of people is most likely to identify service coordination needs?
- Which teams or groups most need to change their attitudes, perceptions, and relationships?
- Who are the best champions?
- What is the weakest link?
- How can supporters influence the skeptics?
- What is needed to get state, regional, and local personnel working together?

Meetings that are carefully crafted to join people **strategically** often produce some creative results.

Step Two--conduct preplanning assessment

Preplanning assessment involves defining the local landscape of the service system already in place to identify an existing foundation for an interagency service coordination initiative. It also involves determining the readiness level of agencies to cooperate (Kochhar & Erickson, 1993).

Following is a format for assessing the strengths and weaknesses of potential partner agencies in their structure, attitudes, and knowledge.

Assessing the Organizational Structure of Cooperating Partners

Understand the diversity of the agencies. Diverse organizational structures make coordination a challenge. Each agency in the collaborative partnership has its own philosophy, structure, procedures, regulations, standards, roles, and responsibilities. This diversity can enrich the process of setting shared goals and is important in evaluating the service coordination effort.

Determine what cooperative agreements and planning processes are already in place. Many interagency relationships lack **formalized** agreements to guide their activities. These agreements are crucial to the development of coordinated activities because they define the common goals and objectives and the local authority for action.

Examine the funding policies. Different agencies have evolved from separate funding streams and public laws. They have different eligibility requirements and different target groups of consumers. Changes in special education, general education, vocational-technical education, and disability laws affect organizational priorities and alter the ways programs are expected to operate.

Look at the existing data collection and reporting capabilities. Within different states and localities, educational and community service agencies report their performance goals and outcomes differently. Each agency establishes its own reporting system, monitoring criteria, quality assurance criteria, performance measurement criteria, annual goals, and plans for services. Agencies must find ways to coordinate data collection and reporting systems.

Consider the economic status. When funds for schools and community services are eroding and local economies are urging fiscal caution, the demand for accountability tends to increase. These forces can intensify the need to share resources.

Identify geographic service boundaries. Educational and human service agencies have different operating territories that may make defining a target population for a local interagency partnership difficult. These boundaries should be discussed as partnership cooperative agreements are being crafted.

Assess the level of parent involvement and family supports needed. Since parent involvement is considered one of the most important factors in the success of students' transition into school, within school, and to postsecondary services, parents' understanding of, support of, and participation in the service coordination process must be determined.

Assessing Partnership Attitudes

Be sensitive to political pressures. As the economic pressures force agencies to economize, interagency planners must show how community linkages can contribute to cost-effective services.

Be sensitive to perceived territorial threats. Encroachments of agencies upon one another's territory can threaten people's comfort with traditional ways of operating and making decisions. Collaborative initiatives usually result in changes in the way everyone conducts business, and this expectation should be made clear to all staff.

Select leaders for continuity in interagency development. Many service coordination partnership failures can be traced to high turnover rates among key personnel in the cooperating agencies. Established relationships among energetic and enthusiastic leaders contribute to confidence and trust. As old links break apart through attrition, the system can weaken.

Assessing Partnership Knowledge

Work to build early understanding among agency personnel about represented organizations and missions. Education and community service sectors must understand each other, recognize differences in their missions, and value complementary strengths. Early interagency collaboration readiness seminars are worth every hour of time, and continued interagency training can keep the momentum high.

Explore and share existing models for service coordination and interagency collaboration. Before developing model practices for service coordination and interagency collaboration, explore a variety of organizational models and management practices.

Gain local college and university assistance. Many college and university representatives have formed relationships with local and state education agencies and community service organizations to provide resources and technical assistance. Graduate students can facilitate inservice training, and faculty can design instructional materials and develop grant proposals.

Understanding what each agency can do and the differences in the kinds of commitments each can make will help interagency planners understand how they can function together as an effective team.

Step Three--assess interdisciplinary, interagency needs

Interagency needs assessment is the process of gathering and interpreting information about the service needs of consumers and their families, the goals of cooperating agencies, and the operational needs of the partner agencies as they invest in real change in programs and environments (Kochhar, 1987).

The needs of educational and community agencies change over time. Needs assessments must be conducted regularly so as needs alter, so can interagency goals and activities. The first defined set of needs provides only a blueprint for establishing early relationships among agencies. As the agencies' activities expand or diminish, cooperative agreements must be revisited and modified.

Financial resources for planning, developing, implementing, evaluating, and sustaining interagency coordination activities are often difficult to obtain. When educational and human services budgets are being reduced, coordination activities may fall under the budget scythe.

Sound and comprehensive needs assessments can prevent the cuts. Planners must show budget decision-makers clear relationships between the mission of the interagency cooperative partnership and the needs of each cooperating agency.

Decision-makers will want to know what common target group is being served by all cooperating agencies and what individual consumer and family needs are being met. They'll also want a clear description of a common goal of linking agency services.

In Chapter 2, you explored in depth eight essential functions of the service coordination process: 1) Information and Referral, 2) Intake and Screening, 3) Assessment and Diagnosis, 4) Individual Program Planning and Development, 5) Service Coordination and Linking, 6) Service Monitoring and Follow-along, 7) Individual and Interagency Advocacy, and 8) Service Evaluation and Follow-up. A thorough needs assessment will determine the capability of each agency to perform these core functions and should result

in recommendations for what each agency must do to strengthen interagency service coordination.

When planning a needs assessment at the individual level, answer the following questions:

- What new health, education, social, vocational, and functional *goalposts** should be set?
- What are the current levels of performance and what are the *gaps** between the current levels and the goals?
- What is needed to close the gaps?
- How can the interagency relationship be structured to help close the gaps?

**Goalposts* are the performance standards set for individual progress and achievement. Once there is sound baseline information on an individual at the time he/she enters the system and the goalposts for him/her to reach are set, the gap between current status and expected future performance can be measured.

An example makes a move from generalizations to specifics:

Making a U-turn in Needs Assessment

Hillbrook High School faculty and Steakout Restaurant representatives formed an education-business partnership. Hillbrook's principal and Steakout's owner talked together many times and agreed that Hillbrook's top priority need was to reduce the number of dropouts.

The partnership conducted a needs assessment, polling only teachers about their impressions of the problem. Because students and parents were excluded from the survey, the root causes of dropout were unclear and solutions to the problem remained a mystery.

This year, the partners began by determining how many students actually drop out each year. Then, the partners set a goal of reducing the dropout rate to 15% from 25%. In addition to surveying teachers, the partners asked dropouts, students at risk of dropping out, and parents what they believed were the causes of the problem and what was needed to solve the problem.

The second needs assessment revealed the partners had been working backwards. Students and dropouts said they needed help in setting short- and long-term goals for their own futures. The partners learned that goal-

setting was the precursor to defining needed levels of academic and vocational achievement.

The revelation changed the focus of the services. The partners now knew what services to develop. The goals of the partnership program were no longer simply locating dropouts and drawing them back to the same school program they had left. The new goals included providing a counseling and career development program to help students assess interests, make decisions, and see the link between earning a high school diploma and getting a fulfilling job. The goals also included pooling school and business resources, defining a cooperative agreement, and developing an annual action plan.

No single agency can meet all individual consumer and family needs. An interagency partnership has a better chance, but even a collaborative group is wise to determine priority needs for services:

- **Priority based on size of the consumer population in need**--Consider which is the largest at-risk group. In any one agency, it might be individuals with limited English proficiency, individuals with disabilities, substance abusers, consumers testing HIV positive, teenagers on probation, individuals with behavioral disorders, unwed mothers, or some other group.

- **Priority based on past resources**--Consider the relative help given to different at-risk groups in the past. For example, perhaps many resources have already been targeted to help chronically ill children, and now there is a need to begin to help children who are in abusive families.

- **Priority based on seriousness of the need**--Consider the relative seriousness of the conditions for different groups of individuals. For example, some problems may represent threats to other children (violent behavior or drug trafficking).

- **Priority based on past exclusion of consumers**--Consider the special needs of individuals who have been excluded in the past from agency services or certain school programs or activities. For example, until recently students with disabilities were excluded from general vocational and technical education classes because they were considered at risk of being hurt.

- **Priority based on expectations for success**--Consider the reasonable chance for program success. If service coordination support is limited, select a group of individuals most likely to benefit from the services and show results.

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Step Four--identify shared resources

Once the interagency planning team has completed a needs assessment, the team needs resources to support service coordination. Following are some reasons for sharing resources and some strategies for stimulating cooperation.

Reasons for Sharing Resources	Strategies for Stimulating Cooperation
Local Control and Determination to Respond to New Laws and Guidelines Local agency representatives design linking systems that respond to new requirements. Goals are designed to meet locally assessed needs.	The new transition service provision in IDEA (PL. 101-476) requires educational agencies to include transition service goals in individualized plans. Local agency representatives should develop procedures for implementing these plans and include specific interagency responsibilities and linkage possibilities. For example, an individualized plan might identify specific vocational rehabilitation (VR) service needs for the individual, the actions VR will take, the time frame within which services will be provided, and the expected outcomes.
Improved Cost-effectiveness Service coordination can reduce duplication of services and use of resources such as personnel and equipment. Reduction of duplication, however, should not be confused with a net reduction of services to children, youth, and families.	If two or more agencies coordinate to provide staff training to meet new early intervention requirements under IDEA, the training can be delivered more economically.
Enhanced Professional Interaction Coordination brings professionals from different disciplines together to share goals and activities, creating a cross-fertilization of ideas that enhances problem-solving and accelerates the process of service coordination.	A local school system lost federal funds for a vocational evaluation center that had effectively served youth with disabilities from several schools in the district. Staff from special education, vocational education, VR, postsecondary vocational and technical education, and business got together to solve the problem by pooling funds. The center was expanded along with the postsecondary vocational-technical program to offer evaluation services for postsecondary program applicants. The joint solution was more creative than any single-agency solution could have been.

Effective Use of Personnel and Shared Recruitment Staff from different agencies can complement one another's talents and skills. Several agencies might benefit from a specialized talent of a particular staff member in one cooperating agency. Likewise, agencies can share personnel recruitment activities and make joint personnel decisions in cases where a staff member may desire a shift from one agency to another.	A staff member from a public health center possessed a talent in inservice training of early intervention services staff. She was assigned the role of liaison among health services, child services, and the educational agency and served as the interagency team training coordinator. She planned inservice training for staff representing all agencies involved in services to infants, toddlers, children, and their families.
Elimination of Service Barriers and Service Gaps Since no single agency can meet the multiple needs of individuals, interaction among agencies is necessary. Barriers among agencies exist because they are separate and different. Together, agency representatives can objectively examine one another's services, identify inefficiencies, and develop shared assessments of service needs. Each agency therefore benefits from the combined knowledge and an understanding of consumer needs from different perspectives.	Educators and community services leaders wanted to assess and improve their ability to serve autistic children and youth in existing programs and services. They needed information about how many diagnosed individuals with autism were in the county system, how many agencies (school-based or community-based) were serving children and youth with autism, and how many could serve more if given greater resources. School-based educational staff, community-based mental health system staff, early intervention staff, adult service system mental retardation staff, and private non-profit vocational training program staff cooperated to conduct a needs assessment among the agencies. Together they identified the size of the population of children and youth with autism, described current needs for services, defined new services that needed to be established, and conducted information sessions with local board members to address the problem.

Comprehensive Interagency Planning for Individual Consumers Shared information can reduce duplication of a great deal of effort.	A community college recently began a support program for learning disabled students. College staff developed the program in coordination with others from local special education programs, vocational-technical education postsecondary programs, alternative education programs, and VR agencies. While the individuals were still in high school, a long-range program plan for college-based and other community-based support services was developed. Information on the progress of these students was shared among cooperating agencies.
Interagency Data Collection and Eligibility Through joint data collection, agency representatives can make comparisons and anticipate service needs. They can share eligibility requirements to match individuals, services, and programs.	A small middle school and a large high school collaborated to share information about students with disabilities transitioning to the secondary level. Educators and service providers wanted to improve planning for placement and support service needs of the students. To meet their shared goals, they developed an interagency data collection system through which the middle school staff provided projections of the needs of youth and their families. Linkages with VR were forged, and referrals for assessment and eligibility determination were initiated for students in the 11th grade.
Interagency Evaluation and Quality Assurance A coordinated system can combine individual agency self-evaluation with an evaluation of its relationships with other agencies. Evaluation from multiple perspectives provides much more valuable information than does a single agency's self-evaluation.	A local education agency and a community service system for adults with disabilities developed a joint evaluation team to examine the link between vocational education programs for individuals with disabilities and job training services in the community. The team of school and community-based staff developed a schedule for quality assurance activities that combined self-evaluation with independent outside evaluation. Evaluation reports were reviewed by a panel of school-based and community-based personnel as well as by each agency's board. Improvement plans were then developed by the cooperating education and community agencies.

Shared Funds In a time of economic austerity, agencies need to share resources to preserve and enhance existing services.	Co-location of agencies can be a cost-effective means of sharing equipment and staff. Co-location also contributes to team building and the development of relationships among interagency personnel. In one semi-urban county, a vocational rehabilitation services agency developed an in-school unit located within the same building as the county public school system's student services and special education office. This co-location has enabled interagency teams to make referrals and complete the assessment and eligibility determination process for rehabilitation services long before the students exit high school.
Community Outreach, Information, and Referral It is important that the community be informed about and appreciate interagency efforts to link services. When the public learns about education and community services through an organized and coordinated public information strategy, the service system is more likely to be perceived by consumers as accessible, supportive of them and their families, and worth the investment of public funds.	Several agencies serving children and youth with disabilities and their families developed a coordinated information and referral system located within the educational agency. Together, they provided information and referral services and a single point of entry to families planning for transition from early intervention services into preschool.

Step Five--establish shared mission

Once needs have been assessed and potential resources identified, the action phase of the collaboration can begin through the establishment of a shared mission. The mission can be for a local partnership only or for a statewide system.

Since each community will describe its partnership mission differently, no two mission statements will be identical. There are, however, some fundamental rules to follow in developing mission statements:

State the context or history. In a brief introductory paragraph, describe the partnership, how it was initiated, the current needs it addresses, and how it improves current practices.

Give the authority. In one section, refer to the local, state, and federal laws, statutes, regulations, and policies that authorize the agreement.

Share the purpose and the expected outcomes. In another section, make a broad statement of what the partnership expects to accomplish and what results it will bring for the participants.

Outline roles and responsibilities. Within the statement, describe broadly what each cooperating partner will do.

Example Mission Statements

Local Cooperative for Early Intervention and Early Childhood Services*

(**Context/history**) In 1988, Hereford County established a countywide system of services to develop a comprehensive, coordinated, multi-disciplinary, interagency program of early intervention services for infants and children with disabilities and their families. The partnership includes the Hereford County Public Schools, Special Education, Division, and the Department of Family Resources.

(**Purpose**) One purpose of the partnership is to develop individualized family service planning to assist young children as they transition from early intervention services into Head Start, other public early childhood programs, and elementary programs. Another purpose is to encourage and provide for the cooperation, collaboration, and integration of efforts in the interagency planning for special needs children and their families as they prepare to enter the public educational system.

(**Authority**) The partnership is a response to the IDEA, Part H (PL 99457 and PL 101-476 Amendments) requirements to expand the state and local capacity to provide quality early intervention services, to expand and improve existing early intervention services, and to create linkages with public education.

(**Broad goal**) To accomplish this mission and to prevent duplication of services to infants, toddlers, and children, each partner agrees to participate in regular meetings for the purposes of sharing information, identifying available resources, and improving participant referral procedures. To provide improved early intervention services and to address the needs of families, each partner agrees to coordinate the efforts of respective service delivery staff to achieve the goals.

**A composite drawn from multiple statements representing multiple localities*

Partnership Mission Statement for Mariner County

(**Context/history**) Mariner County Public School District and the community it serves recognize the need to expand upon and improve the educational training and employment opportunities of youth. In 1988, Mariner County Public School District established the Work Readiness and Training Partnership, a countywide school-to-work skills development and employment training program with Pacific National Bank and Trust. The partnership includes the Mariner County Public Schools, the Human Resource and Development Department of Pacific National Bank and Trust, and the Mariner County Department of Social Services.

(**Purpose**) One purpose of the partnership is to provide social services and on-the-job skills development and employment experience at Pacific National Bank and Trust for Mariner County high school juniors and seniors. Another purpose is to encourage and provide for the cooperation, collaboration, and integration of Mariner County faculty and staff in the planning and implementation of Pacific National Bank and Trust's work training program.

(**Authority**) This partnership is in accordance with the School Board of Mariner County's mandate to expand and improve upon existing vocational and career preparation programs and opportunities for the youth of Mariner County and is consistent with State Regulation 64-5678, which offers incentives to businesses to develop partnerships with educational and human service agencies.

(**Broad goal, roles, and responsibilities**) Each partner agrees to participate in the development of appropriate curriculum materials to assist in the needed career orientation and skills preparation for participating youth. While students are in training, Pacific National Bank and Trust will provide summer and part-time, after-school employment. Pacific National Bank and Trust will give priority hiring to Mariner County High School's graduates, and they will continue to be served by the Department of Social Services.

*Reprinted from Kochhar & Erickson, *Partnerships for the 21st Century: Developing Business—Education Partnerships for School Improvement* (1993). Aspen Publishers, Inc.

Step Six--design cooperative agreement

A cooperative agreement is essential to the development of effective interagency service coordination. A sound agreement

- incorporates the mission statement--*Use it as the opening of the agreement.*
- identifies each partner by full name and describes its resource contributions to support the interdisciplinary, interagency

relationship--*Include staff, funds, equipment, consultation time, vehicle use, space, etc. State the length of time for which they will be contributed and describe any plans to transfer, redistribute, or match these resources.*

- describes the activities to be performed by each partner to achieve the cooperative goals--*Give the authority of the service coordinator and the interagency planning team.*

- defines the expected results for consumer groups being served, for the cooperating partners, and for the community--*Describe the evaluation methods to be used and the evaluation roles to be assumed.*

- establishes timetables for the activities--*Enter the date the agreement takes effect, the schedule for accomplishing objectives, and the times for reviewing, modifying, and terminating the agreement.*

Following are some varied specific commitments, objectives, and actions that should also be described in a cooperative agreement:

- Relevant data to be shared among cooperating agencies (resources shared among agencies, service assessments of consumer needs, rates of program dropouts, needs of children entering elementary grades, services provided to families, projections of individuals entering service coordination activities, etc.)

- Interagency meetings to determine which individuals and families are eligible for services

- Ongoing interdisciplinary and interagency training of service coordinators, teachers, support personnel, counselors, administrators, supervisors, etc.

- Evaluation meetings to determine how effective the partnership is for consumers and families and for the collaborating agencies

- Compliance directives to describe how collaborating agencies will adhere to local, state, and federal laws assuring nondiscrimination in the provision of services

on the basis of race, religion, national origin, sex, and disability

- Confidentiality assurances to describe how collaborating agencies will proceed to protect records and information, e.g., getting written consents, initiating mediation, settling conflicts
- Responsibility assignments that identify the interagency coordinator(s) and other persons with authority
- Termination procedures for ending the relationship among agencies and other related organizations
- Authorization signatures of the responsible persons within each agency along with dates
- Joint attachments such as referral forms, activities calendars, release and confidentiality statements, evaluation instruments

Because a cooperative agreement is a living, active, working document that guides service coordination, it should be bound to a timetable such as the following:

Sample Timetable for Implementing a Cooperative Agreement	
Flexible Time Periods	**Interdisciplinary, Interagency Development Process**
Six months to one year prior to the interagency partnership development	Contact potential collaborating agencies, explore mutual needs and concerns, and conduct consumer and agency needs assessments.
One to three months prior to formal interagency commitment	Obtain informal agreements from agencies identifying needs and human, financial, and material resources each is willing to provide for service coordination.

Several weeks prior to the initiation of the formal interagency partnership	Begin a media and public relations campaign to kick off the service coordination initiative, specify the date the agreement takes effect, design the cooperative agreement, and designate a liaison or a coordinator.
Early fall of the current school year	Recruit and train interagency volunteers and initiate the service coordination activities.
Throughout the fall, winter, and spring	Monitor the service coordination activities by conducting periodic meetings with collaborating agencies, observing, and communicating orally and in writing.
During the last month of the school year	Initiate formal measures to determine if service coordination objectives have been met by examining individual and family records, reviewing and monitoring documents, interviewing participants and volunteers, and disseminating any surveys developed to measure success.
At the close of the school year	Analyze outcomes and then celebrate success by conducting appreciation activities for cooperating agencies.
At a year-end meeting with the collaborating agencies	Review and modify the service coordination program by weighing the results of the partnership: Was it worth the investment? Should it be continued in its present form? If not, what changes are needed?
At year-end	Renew the cooperative agreement, changing components as necessary.

Step Seven--define management structure

Often interagency collaboration begins with just a few shared activities, but as the relationship develops, service coordinators need ways to manage the coordination activities, communicate the mission of the relationship, and measure the benefits for consumers and their families. How the interagency linkage is managed will depend on the number of agencies involved, which agency initiated the partnership, and in which agency the center for coordination of the partnership is located. Management structures can be

simple and loose, or they can be complex with many rules and procedures (Kochhar & Erickson, 1993).

These common observations about service coordination are based on recent surveys of interagency programs:

- There are few rules governing interagency linkages, particularly in rural communities. Linkages tend to be managed loosely with a great deal of local flexibility and discretion over the types of relationships among service agencies.

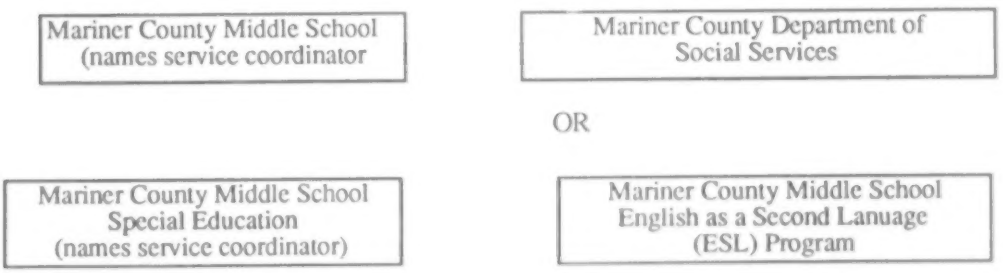
- Educational agencies have been the primary initiators for coordinating and managing partnership activities.

- Large suburban and urban communities tend to have central offices for coordinating interagency activities and are more likely to have extensive guidelines that agencies are encouraged to follow.

- In communities where service agencies are located close together, they are more likely to develop strong linkages, to invest significant resources in meeting priority service needs, and to bring about positive effects for consumers.

There are three types of coordination--simple, joint, and centralized:

Simple coordination--Two agencies (e.g., a school and a health department) are involved in a partnership. The management responsibility is taken by only one partner (e.g., the school). The lead agency provides the direction and designates a liaison/service coordinator.

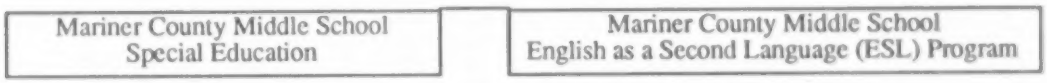


Joint coordination--Agencies coordinate interagency activities from within their respective organizations. Each agency designates a liaison/service

coordinator and has several individuals working as a team. The lead team coordinates the partnership activities.

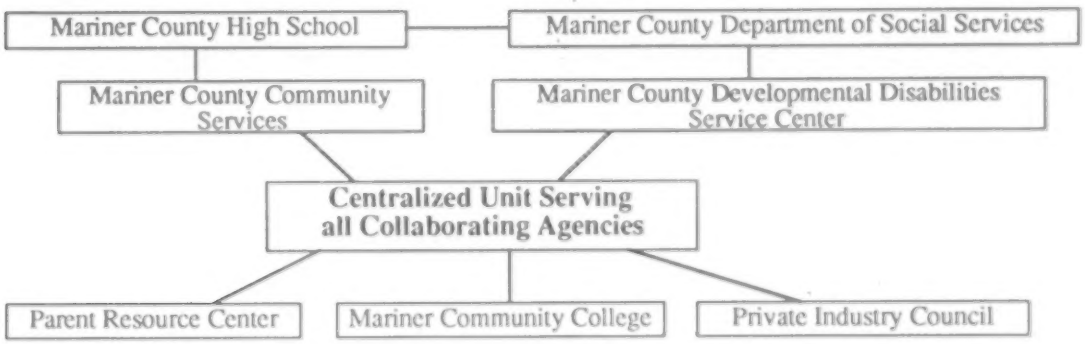
(joint coordination team includes coordinator from each agency)

OR

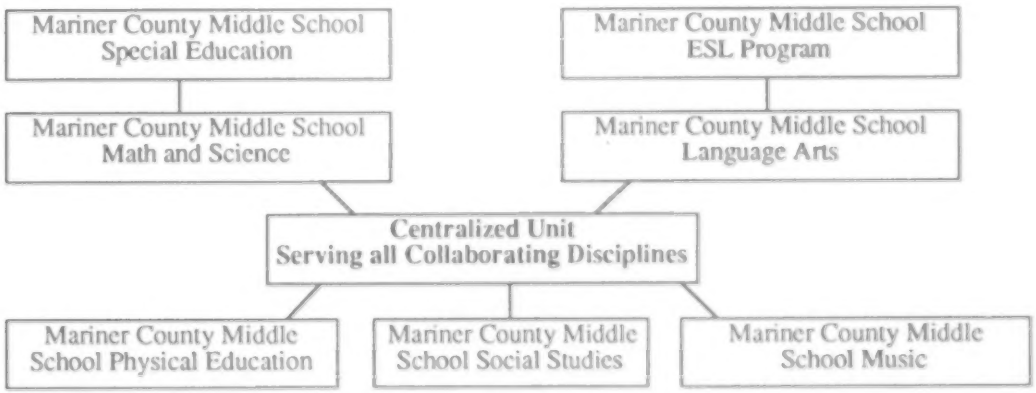

Mariner County Middle School Special Education
Mariner County Middle School English as a Second Language (ESL) Program

(joint coordination team includes coordinator from each discipline)

Centralized coordination--A central unit serves as a link for all collaborating agencies. The unit is a single point of referral or admission for consumers and their families needing to access services from a variety of agencies, for other organizations seeking to join the partnership, and for agencies outside the jurisdiction wanting to coordinate services on a regional basis.


Mariner County High School
Mariner County Department of Social Services
Mariner County Community Services
Mariner County Developmental Disabilities Service Center
Centralized Unit Serving all Collaborating Agencies
Parent Resource Center
Mariner Community College
Private Industry Council

OR


Mariner County Middle School Special Education
Mariner County Middle School ESL Program
Mariner County Middle School Math and Science
Mariner County Middle School Language Arts
Centralized Unit Serving all Collaborating Disciplines
Mariner County Middle School Physical Education
Mariner County Middle School Social Studies
Mariner County Middle School Music

Role of Interagency Coordination Teams

Engaging the wider community in the service coordination process is always important. One way to do so is to form a steering team that implements the cooperative agreement and acts as a community advisory council. The council may be purely advisory or have decision-making authority for partnership operation, its goals and objectives, and its management and staff. The council members must be active participants. Only with the backing of their leadership will school and agency representatives feel empowered to act.

A small group is often more effective than is a large assembly. Some councils delegate specific tasks to a local sub-group called an action team. For example, they may designate a chairperson, a vice chair for liaison with community agencies, a vice chair for interagency training, a vice chair for technical assistance, and a recorder to document interagency team meetings.

The local action team should follow these guidelines:

- Be balanced and include representatives from all the partner agencies
- Formalize long-range plans to ensure the program continues (assuming evaluation results show it is beneficial) and establish a working agreement among principal participants of the partnership
- Be responsive to local population needs and define short- and long-term goals that are locally relevant
- Be committed to program evaluation to determine the benefits of the partnership
- Open lines of communication and support among the top school and interagency organization leaders
- Have the authority to shape the direction of the interagency partnership and its operations, being able to suggest program changes and review goals and objectives set by the partnership
- Be responsive to the needs of the consumer population, examining the program services to determine whether they are reaching the target populations they were designed to reach

- Create a timetable for interagency collaborative activities and program development
- Be involved in or delegate responsibilities for assessing the needs of the interagency partnership
- Be involved in problem-solving for the partnership
- Work to ensure that decisions related to the interagency partnerships are made jointly by collaborating agencies

To set a context for a discussion of day-to-day management, here's an actual case of interagency linkage:

Improving Health Care of Children--The Hillbrook Elementary School, the Hillbrook Department of Health, and the Mariner Insurance Group Partnership

The rural Hillbrook Elementary School, the Hillbrook Department of Health, and the Mariner Insurance Group have been working for a year to assess the health needs of children in the elementary population. After extensive meetings, the partners decided that to improve the general health of students (national education goal #1), the school needed a comprehensive primary health care program. Children could benefit from the following services:

- Diagnosis and treatment of minor injuries and illnesses
- Immunizations
- Dental and visual screening
- Laboratory services
- Prescription and over-the-counter medications
- Health care and nutrition training for parents
- Counseling and family therapy for parents
- Substance abuse education and support

The school principal, the health department director, and the community relations director of the insurance group agreed to call in a management consultant they all knew. The consultant sized up the management needs of the partnership and recommended the essential components of an interagency structure and a variety of management tasks.

Following is an analysis of the consultant's recommendations and the actions taken by the cooperating organizations:

Define roles and responsibilities--The consultant first recommended partners be crystal clear about who would do what in establishing and operating the health services. For example, the insurance company might provide funds for a nurse and for health education seminars, and the health department might help coordinate (or broker) diagnostic and screening services and coordinate the prescription services.

Define the center for operations--The interagency partners next needed to decide where the health program activities would be located within the school; where monthly monitoring meetings would be held; and where orientation, training, and special sessions would be conducted. The insurance company might want to make space available for some of these meetings.

Establish lines of authority and communication--The consultant suggested the interagency team clearly define the lines of authority and communication among school, health department, and insurance company personnel involved in providing health services. She also recommended creation of an interagency organizational chart to inform all involved about the relationships among personnel (who reports to whom); a written, signed cooperative agreement to establish the authority for the activities of the linkage and for the relationships among personnel; and a steering committee to give direction and consistency to the mission.

Implement management tasks--The consultant recommended a wide range of management tasks essential for the implementation and smooth operation of the service coordination program. Some of the tasks she defined required only a few minutes out of the daily schedule; others called for much more time. For example, monitoring a sign-in log for volunteers or documenting financial and material resource donations should take but a few minutes. On the other hand, surveying and then compiling data regarding student and family satisfaction with the program's services could be expected to take much longer.

Regardless of the structure of the service coordination program, there are some essential management tasks:

Budget and funding responsibilities--The service coordination partnership needs to track the resource contributions from the collaborating members. To continue a program beyond the initial year, accounting of costs and financial needs are essential for agency budget planning. The CEO or executive level Board of a business partner must also approve continued investment in the relationship. Data on costs also are crucial for later analyses of the cost-effectiveness of the collaboration. Keep track of

- personnel expenses
- operating expenses
- training expenses
- sources of income
- in-kind resources (office space, paper, telephone, etc.)
- materials and equipment
- staff and volunteer hours (computed in wages)
- fund-raising expenses

In the early planning stages, it is important to do budget planning, considing how the linkage will be continued over the long term, and to make contingency plans if sources of funding should change. Many service coordination linkages fail in their first few years because the agencies did not include continuation costs for the project in their budgets.

Recordkeeping--Several types of information should be collected on an ongoing basis:

- descriptions of services provided
- number of people served
- consumer and family satisfaction
- number of volunteers involved
- agency personnel management time
- total time invested by personnel
- effects of services on individuals
- baseline data before services begin

Public relations--Maintaining communication with the community is an important aspect of service coordination. Look for personnel within collaborating agencies who have talent and interest in public relations activities, graphic arts, or writing. A staff member can be designated as the public relations liaison for the activities of the partnership.

Progress reports--Reporting on progress of the service coordination is an integral part of all management steps.

There are many ways to define the effectiveness of service coordination:

- achievement of interdisciplinary and interagency goals
- participation of consumers in the services being coordinated
- individual benefits from consumer participation in services
- level of effort from agency personnel
- implementation of coordination activities within established timetables
- additional resources attracted through coordination activities
- improved lines of communication among collaborating agencies, consumers, and the community

Progress report information can be gathered through the following sources:

- individual records
- anecdotal records
- surveys
- observations
- tests
- health records
- interviews
- agency personnel judgments
- consumer/family judgments

You may want to report your progress in the following ways:

- monthly updates on activities and consumers' use of services
- midyear assessment of the project's strengths and needs
- annual progress reports
- multi-year, long-range progress reports
- agency, community, and business newsletters
- local newspapers and other media

Staff recruitment, orientation, and development--Part of the management decision-making for the interagency planner or team involves selecting staff within agencies and recruiting program volunteers. These responsibilities typically fall to the designated agency liaison. When several agency personnel are needed to carry out activities, a joint staff selection team can be helpful.

Monitoring and quality management--Monitoring and quality management involve regular oversight of service coordination activities to ensure they are being delivered with a high level of quality. Monitoring is conducted to ensure the agencies and coordinating unit are providing the resources, services, and other benefits that were intended in the original interagency cooperative agreement. *High level of quality* means the activities and services are being provided in a manner consistent with professional and ethical standards; conforming with agencies' policies and regulations; and consistent with other

related professional standards (e.g., health-care standards, counseling standards).

Partnership effectiveness--Evaluation of the benefits of the interagency relationship is essential for its long-term continuation.

Issues Related to Selecting the Lead Agency

Perhaps the most important issue is that of discretionary services vs. entitlement services. Improved outcomes for consumers and their families are more likely to occur if the basic services and supports are required by law (*entitlement*) as opposed to being dependent upon agency choice of provision (*discretionary*). When several services need to be coordinated across agencies and only one or two agencies are required by law to serve, leadership comes best from an agency operating under a clear state or federal mandate.

The lead agency should

- have stable funding
- administer a broad range of services for a broad range of special needs
- have highly developed local and state reporting mechanisms and data base management capabilities
- rank highly the interagency service coordination function
- grant authority to service coordinators to negotiate with directors of service programs

Guidelines for Assessing Environmental Supports

There are many factors in the community that can positively influence the effectiveness of interagency service coordination locally and regionally.

1. Among cooperating agencies, there is a focus on consumer outcomes and benefits in the delivery of interagency services.

2. Planning for statewide interagency service coordination has already begun.

3. Quality review of interagency services coordination and cooperative agreements has already begun.

4. A computerized information system for data collection on children and youth entering and exiting the educational system already exists, or there are plans to develop one.

5. A range of early intervention services and preschool services for children with disabilities is available.

6. A range of vocational education programs and services is available for youth age 14 and older.

7. A range of postsecondary services and supports is available.

8. The cooperating agencies have authority to establish interagency agreements and to cooperate in improving the utilization of services.

9. The service system has a centralized interagency coordination and a single point of referral among all service sectors.

10. Technical assistance exists for development of interagency services coordination.

11. There are established standards for maximum caseload size and a weighted caseload structure to permit flexibility in levels of support or service to allow more direct consumer and family contact as needed.

If the essential supports are weak, then the system should focus its efforts on needs assessment and resource development.

A Closer Look at Caseload Size

There are currently no state or national standards for caseload sizes. Service coordinators agree such standards are definitely needed and should include consideration of the category of activities and the amount of contact needed

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by the consumer. The following list identifies five major activity categories and the probable consumer contact demand of each.

1. **Information and referral**--The individual requests information and referral to the appropriate agency or support service, requiring research, networking, and short-term contact.

2. **Assessment**--The consumer wants service coordination support and needs assessment to determine placement, requiring intensive but often short-term contact.

3. **Active service coordination**--The consumer needs intensive support and ongoing contact.

4. **Follow-along**--The consumer is placed into a secondary or postsecondary program and requires occasional contact and support.

5. **Tracking and follow-up**--The consumer needs no support, but information is collected on the consumer's placement into and completion of programs for long-term follow-up.

Caseload size should be smaller when a coordinator has several consumers in phases 1-3 and larger when most of the coordinator's consumers are in phases 4 and 5.

The following factors serve as a guide for consideration of a caseload's level of difficulty (intensity of support needed by consumers and/or families):

- Types of service coordination status levels assigned for consumers with differing levels of need for support
- Consumer population age
- Consumer disability types and severity
- Number of functions assigned to the service coordinator
- Complexity of consumer/family needs
- Size and complexity of overall service system (urban with high service concentration or rural with low service concentration)

- Geographic spread of services (large in rural, small in urban)
- Direct service responsibilities added to the service coordinator's workload
- Special tasks added to service coordinator's workload (e.g., task force membership, interagency liaison role, needs assessments designer)
- System responsibilities added to service coordinator's workload (service needs reporting, computerized data reporting, etc.)

Step Eight--develop adoption plan

When people sense they are entering an era of change in which traditional ways of doing things are being abandoned, some resist and become negative about the future. An interagency service coordinator has to ask and answer some tough questions: *How can I foster a sense of ownership in the partnership? What should I do to orient agency personnel to the change the collaboration may bring? What kinds of training will be needed? How can the agencies celebrate their successes and honor those who have made contributions to the effort?*

There are multiple strategies for getting interagency personnel involved and keeping them involved. Key to meeting these objectives is creating an adoption plan that includes a series of professional development activities designed to ensure the service coordination initiative is fully accepted by all prospective partner agencies. Strategies must be implemented to prepare key personnel for their new roles and responsibilities, to enlist volunteers, and to secure the support of consumers and their families.

Strategy 1. Link with Local and State Educational Agency Training
Each local and state educational agency organizes inservice training days for teachers, administrators, and support personnel. Interagency planners should use these existing training activities as vehicles for providing an introduction to the new service coordination plans and roles. Representatives of cooperating agencies can be invited to be on a panel with education personnel to discuss the mission and goals of the initiative. Families, consumers, and community leaders can be invited to attend and join in the discussion. Inservice days are good opportunities for sharing information,

presenting concepts related to the change process, and describing the benefits of service coordination for the school district and the community.

Strategy 2. Ensure Participation of All Cooperating Agencies Planners should include staff from all key agencies in training sessions to increase the likelihood of action team personnel sharing a common understanding and vision of the direction of the initiative. The cooperative agreement and annual action plan should include the schedule for training and staff development.

Strategy 3. Develop Interagency Coordination Materials for Training and Distribution These materials should include specific information about the collaborating agencies, including the mission statement, the cooperative agreement, the key roles of service providers, the goals and objectives of service coordination, and descriptions of new services that will be offered through the initiative.

Strategy 4. Explore New Educational and Human Service Practices Interagency planners must help key staff members reassess their agencies' educational and service delivery practices and help them adopt promising new practices.

Strategy 5. Evaluate the Adoption Plan Planners must ask if the training is having the desired effect. Is the training reaching all key agency personnel? Is joint training occurring? Are the participants involved in evaluating the training effort? Ongoing evaluation methods should be included in the cooperative agreement.

Strategy 6. Provide Technical Assistance Planners also should make sure experts provide help during the development, implementation, and evaluation phases. Consultants from colleges, universities, private evaluation firms, and area education agencies can be used on a short-term basis to

- lead problem-solving sessions
- develop assessment and monitoring tools
- design training materials
- conduct advanced training for staff after the interagency team has been functioning for a year or two

- provide information about other programs and their successes and link new local interagency teams with those who are more experienced

The list of strategies ended with some suggestions for using expert consulting services, naming colleges and universities as possible sources. Because every community has access to local and state colleges and universities, more detail about the possibilities of their assistance is useful. Those that have curricular offerings in the following areas are especially good prospects:

- Business-education partnerships
- Special education
- Vocational education
- Early intervention specialist training
- At-risk special education
- Rehabilitation counselor training
- Social work services
- Nursing and health services administration
- Learning disabilities training

Staff Renewal and Celebration of Success

Interagency planners understand there is a need for recognition of all collaborating personnel. Celebrations of individual and program successes will be treasured by those committed to the mission of service coordination. Recognition serves to strengthen commitment and helps develop camaraderie and team spirit. Plans for a reward system should be built into the annual action plan.

There are probably as many ways to reward people as there are people with imaginations. Here are a few ideas:

- announcements in the local media about new programs or special successes of consumers and families
- newspaper articles about the program or individual staff members
- articles in educational agency newsletters, business newsletters, and annual reports
- breakfasts and coffees in which special recognition is given
- banquets to celebrate successes
- photograph displays in schools and community agencies
- plaques for individual achievement and service
- certificates for outstanding contribution and performance
- programs that recognize volunteer of the month or year
- pins and buttons with partnership logo
- dedications of sites or equipment
- small gifts or mementos

Staff renewal is rejuvenation directed at people who have been involved in the service coordination team for some time. Key staff who helped get the linkages started may need to be re-energized. Often these key individuals include the very first champions of service coordination who have done more than their fair share in leading and promoting the initiative. They may simply be tired or feel they have reached a plateau. They may have seen many changes and new directions in the relationship and may no longer feel their roles are valued. They may feel the initiative has given way to routine procedures. In short, they need to renew their sense of commitment, spirit, and purpose.

Promoting renewal goes beyond the recognitions and rewards described previously. Here are some suggestions:

- Conduct retreats in which key personnel review the mission, goals, successes, and contributions over the past years of the partnership and set new directions for the interagency relationship.
- Develop a video that chronicles the development of the initiative, its accomplishments, and the contributions of its key players. The production should focus on benefits for consumers and their families and improvements in service coordination effectiveness.
- Give key players opportunities for new experiences or responsibilities.

- Offer individuals more prestigious roles on interagency teams--opportunities to act as evaluators, public relations specialists, or consultants to other agencies initiating services coordination linkages.

Step Nine--create problem-solving strategies

Interagency personnel share common concerns about consumers and their families, but the commonalities can often be overshadowed by barriers to building partnerships. Barriers can be clustered into three categories:

Organizational barriers--Differences in the ways agencies are structured and managed, in how they define their missions, and in how they provide services.

Attitudinal barriers--Differences in the beliefs, values, and motivations agency personnel have about consumers and families and their roles in the service system.

Knowledge barriers--Differences in the understandings and skills of various agency personnel.

Service coordination initiatives can be much more effective if agency personnel are alert to the barriers. The *Jewish Vocational Service's Guidelines for Interagency Cooperation* (1978) identified several specific barriers to cooperation.

Fears related to the partnership's organization and environment	• No funds available for cooperative ventures • Feuds based on personalities, prejudices, and broken trust • Competition for consumers and resources
Fears about the effects of the partnership	• Possibility of being absorbed into or controlled by other agencies • Recognition that inadequacies may be exposed to the community • Possibility of funding sources disapproving and cutting off funds • Hesitancy to exchange resources for fear of losing them • Perception that change will mean more work or may threaten jobs • Belief that consumers will receive inadequate services • Belief that consumers/families may be labeled negatively

Fears associated with lack of knowledge and communication skills	• No understanding of other organizations' functions • Narrow understanding because a particular group is too specialized • Drained energy from dealing with a large, complex bureaucracy • Inability to cooperate because job demands exceed resources

These fears are still pertinent for agencies seeking to build partnerships in the 1990s.

Recognition of barriers is only a starting place; what is needed are problem-solving strategies to overcome the barriers.

Organizational Barriers	Problem-solving Strategies
Lack of Cooperative Agreements to Empower Interagency Partnerships Many interagency collaboration efforts lack formalized interagency agreements. These agreements are crucial to the development of interagency functions because they define the local authority for action and define common goals and objectives for the total program.	Craft a cooperative agreement to name the interagency partners, identify the resources available, and make explicit the goals of the program. Revise the cooperative agreement to make it more flexible and to allow for situational responsiveness. Model the cooperative agreement after those from experienced interagency programs.
Lack of Shared Funding Policies Different agencies have evolved from separate public laws and funding streams and therefore have different eligibility requirements and different target groups. Sharing funds among these agencies presents a challenge for program development and accountability for outcomes.	Incorporate interagency coordination activities into early intervention, special education, vocational education, job training, and rehabilitation service plans. Discuss strategies for pooling funds across agencies for interagency activities.
Lack of Consistency in Legislation and Agency Priorities Changes in legislation and agency priorities mean changes in the way programs operate. Changes that affect a single agency's services within the partnership affect all cooperating partners.	Help personnel to be aware of public laws and local policies that affect the key agencies involved in the interagency partnership. Build this information into orientation training of staff.

Lack of Incentives for Coordination Each cooperative agency may be evaluated according to different performance criteria. If coordination activities are not part of the evaluation point system, there won't be much attention devoted to it by the individual partners.	Build interagency coordination efforts into the reward systems for each cooperating agency. Design special recognition activities for staff of cooperating agencies to show appreciation for their contributions.
Lack of Adequate Data Collection and Reporting Mechanisms Each agency may report performance differently, using its own reporting system, monitoring criteria, quality assurance criteria, performance measurement criteria, and annual goals for services.	Coordinate agency efforts to collect and share data on participants. Develop data collection procedures jointly with cooperating agencies and relate them directly to partnership goals and objectives. Vary the data to get a comprehensive picture of activities and outcomes (school records, baseline data, interviews, observations, surveys). Keep data collection methods ongoing throughout the development of the interagency initiative.
Lack of Funds to Continue Interagency Partnerships Since funds for education, health, and social services are eroding and the demand for accountability is increasing, pooling of resources for coordination is essential.	Document carefully the operating expenses, resources and income (to include in-kind resources), materials and equipment, and human resources devoted to service coordination.
Lack of Flexibility for Crossing Geographic Service Boundaries and Selecting Participants Agencies often have defined service territories and target populations to be served.	Consider giving priority to participants who have the greatest need and potential for showing gains.

Knowledge Barriers	Problem-solving Strategies
Lack of Understanding among Interagency Personnel about Their Respective Organizations and Missions Service providers need to understand one another, their distinctly different missions, and their complementary strengths.	Develop interagency training sessions and share descriptions of agency missions, goals, and objectives.

Lack of Adequate Interagency Models There is a need for new models for interagency collaboration development and improvement of interagency relationships.	Develop common terminology, define common coordinating activities, use cooperative agreements, define core activities, define outcomes, and identify target populations. Locate interagency models in other areas and states and discuss them in team meetings.

Step Ten--evaluate for improvement

Though evaluation appears as the final step in developing interagency relationships for service coordination; it is actually an ongoing process. Evaluation is focused on how well the interagency partners are accomplishing the goals in their cooperative agreements and to what extent consumers and their families are benefiting from the cooperative activities. Here is a brief introduction to the concept of evaluation. (Chapter 5 offers an in-depth look at how to evaluate service coordination initiatives and how to use the evaluation results for decision-making and planning for future system change among cooperating agencies.)

A Basic Vocabulary for Partnership Program Evaluation

There are many types of questions that can be asked to determine how effective interagency service coordination is for the consumers and their families being served and for the cooperating partner agencies. These questions are categorized into three classes: **inputs, processes,** and **outcomes**. Evaluation methods belong in two basic classes: **formative** and **summative**.

> *Formative evaluation* activities occur during the continuing development of the cooperative relationships among agencies and are designed to answer these questions: How well is the planning, designing, and operating of the interagency partnership going? Are the processes developing the way the cooperative planning team originally intended? Ongoing evaluation yields useful information to guide adjustments as the cooperative relationship develops and begins new activities (adapted from Rossi, Freeman, & Wright, 1982).
>
> *Summative evaluation* produces information about the results of the service coordination and is designed to answer these

questions: What results are occurring for consumers? How is the new relationship benefiting the cooperating agencies? Summative evaluation information involves judgments about the worth of the service coordination activities and is useful for making changes in the management or implementation of the activities and the resources that support them (adapted from Rossi, Freeman, & Wright, 1982).

Both formative and summative evaluation are needed for a thorough picture. They require evaluation of all of the components of a cooperative partnership. There are three types of measures: inputs, processes, and outcomes.

Inputs (What goes into the effort during interagency planning?) Inputs include resource contributions from each agency: staff, funds, equipment, transportation, consultation time, space, etc. Specify the design and framework of the interagency services, including the participants to be served and the service strategies to be implemented.

- At the individual level, participants are the primary inputs for the partnership.
- At the service or system level, the cooperating partners and the resources they each contribute represent the inputs.
- Inputs also include the partnership's goals and objectives.
- Informal inputs include the support of family members, friends, and others in the consumer's circle of support.
- Formal inputs include service providers such as teachers, specialists, health care workers, social workers, job coaches, employers, guidance counselors, mental health counselors, administrators, and many others.

Processes (What do cooperating agencies actually do in providing interagency services to participants?) Evaluating program processes means examining the interagency partnership's procedures for the delivery of services. Seek to determine whether the interagency partnership is operating consistent with its design and reaching the target population.

Outcomes (What do agencies hope to see change as a result of service coordination?) Outcomes evaluation records the extent to which interagency coordination activities result in desired changes in the target consumer population and in the service delivery system as a whole.

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CHAPTER 4: The Coordinating of Services from Infancy to Adulthood

You now know the philosophical underpinnings of service coordination, you understand its eight basic functions, and you have explored the ten steps of the service coordination process. Principles, functions, and steps give you a conceptual overview, but you're probably still asking, "What really happens?"

The strongest characteristic of service coordination is its variety. The possibilities are endless and depend primarily on the creativity and perseverance of participants engaged in the process. This chapter is designed to suggest some of those possibilities by showing you what others have tried in their efforts to serve consumers ranging from infants and their families to youth and adults.

Focusing on Infants, Young Children, and Their Families

For no other population is a family orientation more important. Serving infants and toddlers almost always means serving their parents and/or other caregivers. Because parents most in need of support are often barely more than children themselves, they're apt to need help in strengthening their nurturing skills, their decision-making skills, and their sense of worth and responsibility. Several of the examples that follow are designed to aid parents on behalf of their infants before and after delivery.

Example #1: Child Survival/Fair Start Home Visit Programs
(Adapted from Meisels & Shonkoff, 1990)

In 1982, the Ford Foundation launched the Child Survival/Fair Start (CS/FS) Initiative, through which it has sponsored community-based strategies to improve pregnancy outcomes and infant health and development among low-income families. At the heart of this initiative is a network of lay home-visit programs coupled with independent sponsorship and operation.

The five programs of CS/FS reach high-risk populations: migrant Mexican-American farmwork families in two Florida farm labor camps; Haitian immigrants and refugees in Ft. Lauderdale and Immokalee, Florida; young black (mostly unmarried) mothers in the three poorest counties of west

Alabama; isolated rural families in six Appalachian counties; and urban Mexican-Americans in Austin, Texas. Home visitors come from the target communities. In the migrant program, for instance, they are either former farmworkers or members of farmworker families.

Following one young mother as she participates in the program will show you how service coordination served her. Meet Otilia.

Otilia is a 16-year-old high school student who is pregnant for her first time and is participating in the Fair Start program in her school. She has been linked with a team of professionals, including a nurse practitioner, a child development specialist, and a social worker. As part of her own service coordination team, Otilia worked with the others to develop her individual service plan.

As part of her plan, Otilia enrolled in prenatal care and Medicaid, and she received support from the nurse and social worker as she practiced good nutrition and learned the skills she would need to care for her newborn. She began receiving home visits during her third month of pregnancy. The visits continued monthly until the last four weeks before her expected delivery date, when the nurse visited her weekly.

Frequent home visits continued until her baby was 24 months old. After the baby's birth, the service focus shifted to what Otilia then needed most: support in developing a healthy mother-infant relationship, assistance in learning to give her baby loving day-to-day care (including feeding, hygiene, and stimulation activities), skilled assistance with managing infant illnesses, instruction and support for providing well-baby health care (check-ups, immunizations, etc.). As Otilia became more skilled at caring for her baby, she was ready to plan her future. The other team members were there to help.

Throughout Otilia's enrollment, home visits remained an integral part of her support system. Here's a snapshot of just one of those visits.

> *The home visitor got caught up with Otilia on significant events since the previous visit. She checked to make sure Otilia had kept scheduled appointments for herself and her baby. They talked together about particular health and child development topics that Otilia had been thinking about. The visitor watched as Otilia bathed her infant son and then demonstrated some stimulation activities she thought both the baby and the mother would enjoy.*

She reminded Otilia of upcoming appointments and gave her lots of time to share her feelings, her questions, and her plans for the next few days. Otilia says she's not ready to think beyond then, but she and the visitor agree it will soon be time to do some serious planning for her own ongoing development and for ensuring the continued good care of her child.

Otilia's individual service plan was a collaborative product and was being implemented by the consumer and a team of caring professionals representing a variety of agencies and volunteer services. Ask yourself these questions:

> Which of the eight basic functions of service coordination were in operation? (Force yourself to defend your answers with evidence from the example.)
>
> How important was Otilia's role in the service coordination process?
>
> Is a mother-child orientation the equivalent of a family orientation?

Example #2: The Prudential Foundation's Zero-to-Three Parenting Project (Adapted from the Council for Aid to Education, 1992)

This parenting project for teen mothers (ages 12-16) was operated for three years by the Youth Development Center in Newark, New Jersey. The project provides a therapeutic parenting program for the teens, their newborn infants, and their extended families. It is aimed at providing supports to train new mothers in infant care, to assess infant-support service needs, to help mothers access early intervention services, and to prevent intervention by protective services or foster care services. The Prudential Foundation provided a $75,000 three-year grant to fund the Zero-to-Three parenting project.

An edited excerpt from the project files illustrates some aspects of the service coordination process in action:

June was a pregnant high school student when she entered the Zero-to-Three project Her individual service plan was designed to meet three goals:

- *To provide mental health therapy and service to June and her infant in a family setting to improve her relationship with her infant*

- *To promote June's self-esteem and further her academic and vocational education*

- *To garner peer support for June to reduce the likelihood of repeat pregnancies and to encourage her to stay in school*

The program began with an in-home assessment of June's needs and her family's needs. The service coordinator used data from this assessment to develop June's family service plan, which included

- *weekly clinical sessions with June and her infant, formatted on an infant mental health model*

- *biweekly intervention sessions with June's family*

- *weekly group sessions with June at her high school*

- *monthly meetings of the service coordinator, June's teachers, and other school staff involved with June*

- *an evaluation of the services by June, her family, and the school staff to measure the effectiveness of the program*

Though the information is limited, you probably sense significant differences between this program and Example #1. Try tackling these questions:

> How large do you think June's role was in developing and monitoring her individual service plan? What are the implications?
>
> How measurable were the program's objectives? Were they designed to determine June's growth in the program and gaps still needing to be closed?
>
> If you had a daughter in need of these kinds of services, would you recommend this interagency system to her? What do you infer to be pros and cons?

Example #3: A Shared Responsibility for Early Intervention
(Adapted from Levy & Shepardson, 1992)

(Notice the difference in title. There's no program name because this example illustrates collaboration at the administrative level as a means of enhancing many services for early intervention.)

A large semi-urban midwestern county had recently received a community collaboration grant to develop early intervention services for infants, toddlers, and children with disabilities and their families. The initiative was led by the head of Developmental Disabilities Services, who formed these committees and boards:

- *Developmental Disabilities Planning Council*
- *Substance Abuse Services Planning and Coordination Board*
- *Pediatrics Coordinating Task Force*
- *Child Abuse Prevention Task Force*
- *Family Support Services Coordinating Committee*

These boards and committees joined to form a Local Interagency Coordinating Council (ICC). They began to collect information from service providers and schools about the kinds of services needed and the obstacles that existed. They established a local resource and referral center for families seeking information about early intervention services and developed a plan to establish the following:

- *Interagency service coordination for children, youth, and families*
- *Public awareness activities*
- *Volunteer services corps*
- *Assessment processes for determining access barriers*
- *Screening and assessment*
- *Parent supports and toy-lending programs*
- *Shared staff training*
- *Transportation services*
- *Technical assistance to cooperating agencies from state universities*
- *Quality assurance and program evaluation*

The ICC is now in the process of designing an evaluation of this effort.

This is an example of service coordination by collaboration, not mandate. Preplanning assessment (defining the service system already in place, determining the readiness of agencies to collaborate in interagency service

coordination, and determining the strengths each agency brought to the ICC) was an essential first-step.

> What value do you see in such efforts at the administrative level?
>
> What obstacles did the groups likely encounter?
>
> What questions might you want answered if you were helping to plan the evaluation?
>
> Is there a group like the ICC operating in your area?

Example # 4: The Annie E. Casey Child Welfare Reform Initiatives
(Adapted from Cities in Schools report, 1991)

The Casey Foundation is a private philanthropic organization dedicated to improving the nation's foster care system. The Child Welfare Reform Initiative (CWRI) helps selected states redefine their child welfare role and develop more practical and proactive methods for communities to enable parents to be better caregivers, thereby preventing the need for intervention by the child welfare system. Beginning in 1988, the Foundation awarded 5-year CWRI grants for $3.75 million in North Dakota, for $7.5 million in Maryland, and for $7.5 million in Connecticut.

States and communities are required to develop new systems of services that are more family-centered and more comprehensive and flexible. Reform initiatives are to meet these criteria:

- *Initiatives must be focused on serving at-risk families before crises occur.*
- *They must foster strong community ownership of the services and protect the rights of children and families.*
- *They must seek to prevent unnecessary out-of-home placements by creating collaborations among service agencies and ensure accessible supports for families that engage earlier and are preventative and comprehensive.*

- *They must have adequate authority to plan and lead service delivery changes.*

- *Refinancing of services must promote, rather than inhibit, collaborative service goals.*

- *Initiatives must provide financial incentives to maintain children safely in the home and to support an integrated program for serving at-risk families.*

With the greater flexibility provided, local community CWRIs are expected to create service coordination systems that reduce out-of-home placements and family crises.

CWRI is an example of interagency service coordination at the administrative and service provider levels--this time by mandate. Here the mandate is a function of funding, not law.

> What advantages and disadvantages do you see to interagency coordination by mandate vs. voluntary collaboration?
>
> What differences would you expect to see in the first stages of organization under CWRI and under an arrangement such as the ICC in Example #4?

Serving Pre-adolescents, Teens, and their Families

Many service coordination programs target upper elementary and middle school students and their families but also serve high school students. The next example introduces one such program built on a specific interagency service coordination model. The focus is on interagency collaboration to serve a specific population though the services themselves are tailored to the needs of individual children and their families.

Example #5: The Great Potential Program
(Adapted from Levy & Shepardson, 1992)

Great Potential began in 1987 through a partnership of SUNY

Purchase Westchester School Partnership, the Community At-risk Youth program, Liberty Partnerships program, and the Cities in Schools program. The partnership began with a $98,500 grant from Kraft-General Foods in one high school.

Great Potential is a school-based program designed to address the educational and developmental needs of young people identified as at risk of not completing school. The program's mission is to foster a collaborative effort to motivate, educate, and maintain students who otherwise would likely be unable to achieve personal and school success.

Through the program, students are assessed for personal counseling, tutoring, vocational exploration, and job skills needs. The program offers services and training in each of these areas, provides prevocational orientation, helps in finding part-time and summer work, and offers advice and support to parents. An advisory board made up of representatives from the schools, community agencies, businesses, and politics keeps the program focused on its goals--to coordinate the delivery of a range of support services to students at risk and to address school needs to meet workplace demands.

School-linked service models represent a new effort to restructure the way health and social services are coordinated and delivered to school-age children and their families. The Great Potential program incorporates this model and was developed to increase collaboration among a number of service agencies working toward common goals.

These are standard expectations in a school-linked approach:

- *Services are provided to children and their families through a collaboration among schools, health care providers, and social services agencies.*
- *The schools are among the central participants in planning and governing the effort.*
- *The services are provided at or are coordinated by personnel located at the school or a site near the school.*

The approach often requires health and social services agencies to move some of their personnel and/or services to the school site. The rationale for going through this change is twofold: that schools are enduring, dominant institutions in the community and that there is a connection between

improving academic performance and linking nonacademic services to the schools.

These guidelines for implementing a school-linked approach to service coordination reflect its implicit philosophy:

- *Alter how participating agencies deliver services to children and families and how they work with one another.*
- *Do not allow planning and implementation of school-linked programs to be dominated by any one institution--whether it be a school or an agency.*
- *Create services that are comprehensive and tailored to the needs of individual children and their families, emphasizing at every level a family orientation.*
- *Ensure that each participating entity redirects some of its current funding to support the collaboration.*
- *Be willing and able to collect data about what is attempted, what is achieved, and at what cost.*

What benefits do you see in the school-based model? From your perspective, what are its shortcomings?

Are the guidelines for the school-based model reasonable? Are they useful? Are they adaptable to other interagency coordination efforts?

Example #6: The Passage from Middle School to High School
(Adapted from Levy & Shepardson, 1992)

Educators in a small suburban middle school and a large high school were concerned about the poor adjustment of students with disabilities as they moved from one school to the other. They met to discuss ways to anticipate needs and improve the adjustment of the target students to the large high school environment.

The specific outcomes they sought included

- *better academic performance*

- *better access to and performance in prevocational and vocational training programs*
- *decreases in health-related absences*
- *fewer absences*
- *lower dropout rates*
- *increased participation in social and extracurricular activities*

They decided on several strategies that combined cooperative planning between schools with interagency service coordination:

- *Holding small orientation sessions for the middle school students to discuss the following year's transfer to the high school, to learn what to expect in the new environment, and to receive information about the support system there.*

- *Conducting joint (middle and high school) orientation seminars for parents and families to discuss the transition, encourage their involvement, address their questions, and suggest support strategies.*

- *Distributing jointly produced information packets to students and their families to let them know requirements and expectations, to highlight the possible impact of the change in environment, and to invite them to make use of the support available.*

Parents and students were invited to visit the high school and meet with new teachers. Team meetings between middle school and high school teachers were held to discuss the strengths, needs, and concerns of individual students. To improve access to and coordination of support services, quarterly interagency meetings were established to increase cooperation between designated school personnel and the many agencies available to offer additional services to these students.

An interagency data collection and sharing system was developed to help middle school personnel project placement and support service needs of students and their families. Placement projections were matched with projections of vocational and cooperative education program openings and shared among cooperating agencies. Additional assessments were conducted to learn more about career/vocational preparation needs, family support service needs, assistive technology and classroom accommodation needs, counseling and psychological services needs, health and medical needs, and social services needs.

This was another effort to serve a discrete consumer population. Though you're given no evidence the intended outcomes were achieved, you can assess the beginnings of this collaboration:

> Have roles and responsibilities been sufficiently defined?
>
> Are intended outcomes measurable?
>
> Does the group have sufficient baseline data?
>
> Are the measures they've taken to inform and involve constituents sufficient? What might you add?
>
> Is there sufficient emphasis on self-determination and consumer decision-making?

Supporting Young People in Transition to Adulthood

The first two of the remaining examples describe collaborative multi-agency transition processes in two states. The third example shows you how a rural community has addressed transition needs. The last two introduce you to Phan and Maria, young adults who are participants in service systems.

Example #7: The Iowa Transition Initiative

(Presented with permission of Dee Skeens, Director)

The Iowa Transition Initiative represents a statewide movement to improve the transition from adolescence to adulthood for young people with disabilities. Its transition process is accomplished through the cooperative planning efforts of the following representatives comprising each transition team: the individual being served, his/her family or guardian, educators, service providers, and employers. The individual and his/her family or guardian are the heart of the team; other members are to plan with them, not for them.

Area Transition Advisory Boards (TABs) across the state give support to individual transition teams. TAB members are aware of the activities used with individuals and their families or guardians within their merged geographic areas. TABS serve as resources to multi-disciplinary teams

throughout the process; their involvement increases as individuals approach and enter adult life.

Under the Initiative's best practices guidelines, the transition process begins at age 12 and continues into adulthood. It consists of four overlapping components—awareness-building, identification of needs, planning and implementation, and adult living—and concentrates on development in ten critical areas: academic and life-long learning, health and physical care, mobility, social interaction, occupationally specific skills, self-determination, daily living, leisure, money management, and workplace readiness.

More than just another component, evaluation is an ever-present element and always includes examination of the appropriateness of the transition plans and their implementation, individuals' progress, individuals' satisfaction with the transition process and its outcomes, parents'/guardians' satisfaction with the process and outcomes, multi-disciplinary team members' involvement in and satisfaction with the process, and the contributions of area TABs.

Evaluation is emphasized at every stage as a means of identifying whether goals and long-term directions are appropriate, whether interventions are working, and what modifications in interventions and/or expected outcomes are indicated. Input from individuals and their families/guardians is essential at every level.

The Iowa Transition Model is currently being introduced in many communities within the state. With full implementation, the model is expected to increase the number of individuals with disabilities who lead productive, satisfying lives and to make successful collaboration among educators and other service providers a common occurrence rather than an extraordinary one.

The Iowa Transition Initiative is just one example of efforts at the state level to improve the transition process for young people with disabilities. It relies on best practices guidelines rather than mandates to bring about change.

> Why do you think a number of states (Iowa and Virginia are two of the leaders) are concentrating on service coordination to facilitate the transition from youth to adulthood?

What strengths do you see in the Iowa Transition Initiative's approach?

What problems likely will be encountered in implementing its transition model at the local level?

If you were in charge, what steps would you take to increase the odds for successful implementation of the model?

Example #8: Statewide Interagency Transition Services in Virginia
(Contributed by S. Defur and D. Hiltenbrand from an unpublished paper, 1991)

After the passage of PL. 98-199 in 1983, state and local education and rehabilitation leaders in Virginia worked together to develop and expand transition services. In the early stages of development, the state obtained assistance from federal demonstration funds through the Office of Special Education and Rehabilitation Services (OSERS) in the U.S. Department of Education. Virginia's initial state transition projects promoted several types of services:

- *Initial and ongoing career and vocational assessment*
- *Interagency coordination and comprehensive transition planning*
- *Job placement services and postsecondary follow-up*
- *School and agency personnel awareness*
- *Technical assistance*
- *Transition coordinating councils at state and local levels.*

State leadership recognized the need for systems change to integrate transition services into local systems. The two best strategies were believed to be a) the development of demonstration model projects infused into local systems and b) state-level transition coordination and leadership.

Early in 1983, five state agencies came together as a team to address the interagency planning needed to begin transition services for youth and young adults with disabilities. These agencies included the Department of Education, the Department of Rehabilitation Services, the Department of Mental Health, Mental Retardation, the Division for the Visually Handicapped, and the Virginia Employment Commission. This state transition team formed a core leadership group which began their mission by studying transition needs within the state.

The leaders of these agencies provided continuity for the development of federal grant proposals and technical assistance in the early stages of the team effort. Vocational evaluation and interagency services coordination were among the first to be identified as needed services. The state transition team undertook three initiatives in the form of model programs:

***The Postsecondary Education Rehabilitation Transition Program (PERT)**--A demonstration project for implementing comprehensive vocational evaluation and interagency planning at the local school level cooperatively developed by the Department of Education and the Department of Rehabilitation.*

***Project PLACEMENT**--an interagency project designed to provide job placement services to youths who had received vocational education as part of their secondary schooling.*

***Project VAST**--a federally funded project to establish a process at state and local levels to ensure that education, rehabilitation, and adult service agencies provide cooperative longitudinal transition planning and service delivery for youth with disabilities. Under the project, transition services focused on career preparation, employment, independence, and successful life adjustment.*

Virginia has continued its commitment beyond these early model projects. The Virginia Transition Task Force was initiated in 1990 to further statewide coordination of transition services. State and local representatives from the original thirteen agencies and community representatives of business and industry, consumers, and parents are to comprise the thirty-three-member task force. The Department of Education has coordination responsibility for this group, but the work of the task force is completed by committees with task-force consensus.

The task force also serves as a forum for discussion of transition issues raised by the public. Task force members take recommendations to their respective agencies/groups for discussion and possible enactment.

Virginia is setting an agenda for future statewide transition services that preserves state leadership but requires greater local commitment and control. The task force has identified these major areas to be addressed: agency policy development, funding for transition service support, confidentiality issues, development of interagency training programs, and collection of data that will clarify the status of transition services and identify gaps and barriers to their provision.

The description of the Iowa Transition Initiative concentrates on the transitioning process itself; the description of Virginia's focuses on the process for developing the transition process.

> What does the Virginia example tell you about the **process** of creating a successful statewide transition program?
>
> Did you judge the three model programs to be appropriate starting places? Why/why not?
>
> How did the initial state transition team and the later statewide transition task force further interagency coordination?

Example #9: A Rural Community Works to Improve Transition Service (Adapted from The Community Alliances to Support Education report, 1991)

For years, educators in this small rural school district—call it Hometown—had been unable to improve job opportunities for high school students with disabilities. School officials; special, general, and vocational education teachers; private non-profit job training organizations; local vocational rehabilitation administrators; and business leaders finally met and agreed to form a partnership. After several meetings led by a special education supervisor, group members decided to apply for federal funds to help develop vocational and technical skills training for youth to keep students involved in school and help them prepare for the transition from school to work.

The partners agreed to work together to establish a vocational-technical education center that could serve all youth in each of the area school districts that elected to join the cooperative. They also wanted the local employment services agency, the community-based adult disability service system, and the local community college involved.

Each district had to dedicate some of its own resources to the development of the vocational-technical education center. The agency representatives developed a cooperative agreement that included the following: a long-range plan, a decision-making advisory committee to guide partnership efforts, and clearly defined results they expected from each of the cooperating agencies.

They also decided the program needed to have enough autonomy to operate as a distinct entity to carry out its shared functions in a manner that equitably served the competing needs of all cooperating school districts. These functions included

- *district-wide transportation*
- *vocational-technical education and training services*
- *job placement and support services*
- *intake and assessment*
- *individual program planning*
- *cooperative work experience*

The newly formed regional center, a planned and shared intervention, developed its own identity and had its own operational boundaries but remained interdependent with the cooperating school districts.

> How might a local effort such as this profit from the support of a statewide program like the Iowa Transition Initiative?
>
> Why are both local and statewide collaborative efforts essential to successful interagency service coordination?
>
> Can you identify problems likely to occur when both state and local groups are operating their own initiatives? Identify three steps at the state level and three at the local level that might be taken to reduce conflict and/or increase mutual support.

Example #10: Phan, A Refugee from Vietnam: Service Coordination to Address Language Deficiencies and Cultural Integration
(Contributed by Dr. William Sullivan, Arlington Career Center, Arlington, Va.)

Phan was among the second wave of refugee children entering the community and school district. Phan was born in North Vietnam, but fled the country as the Vietnam war was ending. After living in refugee camps, he emigrated at age fourteen to Arlington with his family under the sponsorship of a local refugee organization. Phan's parents spoke no English, had very few work skills, and suffered chronic debilitating illnesses.

When Phan entered the high school High Intensity Language Training (HILT) program, it was quickly determined that he had limited English capability and a poor prognosis for academic achievement. In the large

high school setting to which he was assigned, Phan rarely chose to speak at all, could not respond to questions given in English, demonstrated limited math skills, and appeared generally confused.

He was immediately staffed for special education placement, and, on the basis of the test data, he was labeled educable mentally retarded and placed in a self-contained special education program. As part of his placement, Phan was also enrolled in the Education for Employment (EFE) program at the Career Center, established for students with disabilities. Through the EFE program, Phan gained hands-on experience to acquaint him with vocational skills areas. He showed himself to be a responsive, alert individual who quickly grasped mechanical and spatial concepts.

Since Phan's academic performance was not improving, the high school requested that the Career Center provide Phan with an educational program that reflected his interest and motivation. Phan was released from the academic program at the high school and enrolled in a printing program under the direction of a teacher who had extensive experience with HILT students and students with disabilities.

Within two months, Phan mastered the basic principles of press operation, could measure and cut paper using sophisticated measurement concepts, and was able to read and follow directions on safety and machine operation. To help Phan stay in school, the instructor and the coordinator of vocational programs for special needs students secured him part-time work as a press operator with a local printer.

Phan was immediately successful in the job, earning high praise from his employer. He agreed to return to the high school HILT program for further classes. The HILT teachers structured an academic program for Phan that enabled him to continue working as he earned credit toward a high school diploma.

What might have contributed to Phan's original poor placement and to what was likely an inaccurate original diagnosis?

What evidence is given of effective service linking?

Not only did Phan do much better under the EFE program, the right people noticed. What does this example show you about the need for adequate monitoring and interdisciplinary and interagency communication?

Who was acting as Phan's service coordinator?

Are young people like Phan more apt to get the right teacher, counselor, social worker, or vocational therapist by way of a formalized service system or by luck? Do service systems in your area improve the odds?

Example #11: Marie from El Salvador: Against All Odds
(Contributed by Dr. William Sullivan, Arlington, Va.)

Maria is a twenty-year-old student from El Salvador who came to the U.S. with her twelve-month-old daughter. Maria contracted polio as a child; as a result, she must use crutches to walk. When she was a young teenager, her mother came to the U.S. to work as a domestic, leaving her behind with a grandmother. Maria had one or two years of formal schooling in El Salvador and reportedly spent much of her time in the streets with groups of other young men and women. Upon entering the U.S. as a documented alien, she moved in with her mother.

Because of her age and education deficits, the intake center recommended she attend a High Intensity Language Training (HILT) program for refugees who had minimal high school eligibility remaining. She was enrolled in HILT and also in a data entry program at the Career Center. She was determined to be eligible for special education as learning disabled and physically disabled. She remained in her current placement since it was the best available to help her develop needed skills and learn to function independently.

Maria's vocational assessment indicated training in the clerical field. Maria exhibited skills suitable for a data entry operator, mail clerk, and general office clerk. While Maria was still enrolled in the data entry program, she was referred to the Virginia Department of Rehabilitative Services for assistance with mobility training and certification for employment.

Maria was placed in a part-time job for one day a week as a mail sorter for a local graphics company. This job lasted two months and was terminated because she was unable to secure child care and transportation problems to the work site were too difficult to overcome.

Maria continued the data entry training and her academic program. Her skills reached almost entry level. With the assistance of the job placement

coordinator, Maria secured the aid of a mentor to help with social skills and provide friendship. She was then recommended for a second part-time job (she had acquired legal work status), which she kept as she continued her formal training. Maria received her high school certificate of completion within the year, and her future as a productive employee seems secure.

Both Phan and Maria achieved positive outcomes, but there were real differences in their needs and experiences within their respective service systems. Consider those differences as you answer the following questions:

> What complications did Maria face in her struggle to be an independent adult? How well did her service team help her address those complications?
>
> If you had been Maria's service coordinator, what might you have done differently to support her development as a parent, a wage-earner, and a competent citizen?
>
> What service-team priorities do Phan's and Maria's experiences emphasize?

Just as abstract descriptions and explanations have their limitations, so do examples. The eleven sketches presented here allow you to look only at slices of service coordination at interagency and individual levels. Adapting the illustrated concepts to make them work in your setting is your responsibility.

Chapter 5: The Evaluating of Service Coordination for Program Improvement

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CHAPTER 5: The Evaluating of Service Coordination for Program Improvement

This chapter introduces evaluation as a vehicle for renewal and improvement of service coordination. The focus is on the practical uses of evaluation techniques at local and state levels. You'll gain some insights about how to design evaluation for service coordination and how to use evaluation results for decision-making and planning.

Evaluation--How Does It Aid Interagency Service Coordination?

Evaluation of service coordination provides information about whether and to what extent linkages among education and/or human service programs are actually helping individuals and their families. It is a coherent sequence of activities by which information about interagency relationships is collected to

- find out how powerful the results or effects of the interagency collaboration and service coordination are for facilitating progress of consumers and improving services
- determine whether the interagency partnership is achieving established goals
- determine the value and benefit of interagency relationships
- help in making decisions about improving programs and linkages (Erickson & Kochhar, 1991)

Though benefits to clients are the most important outcome for any service program, decision-makers and funding agents must also be concerned with costs of services. It is therefore important to convey how the service coordination activities are justifying the resources being invested. How the service system answers this question will be a determiner of the level of commitment funding agencies make to the future of the interagency partnership under review.

Classification of Evaluation Activities

There are two ways of classifying evaluation: according to activities and according to the measures applied. You already examined the classification by activities in Chapter 3, so what follows next constitutes a review.

The two kinds of activities are formative and summative:

Formative evaluation includes activities that occur during the **formation or development** of the interagency relationships and are conducted to answer specific questions about how the program is operating or how effective it is. How well are services being planned for or coordinated? Are agencies collaborating the way the planning team originally intended?

Formative evaluations often include evaluation of admission and selection processes, review of program procedures, ongoing quality reviews, and/or periodic case reviews. Ongoing formative evaluation provides useful information to help participants make adjustments as interagency collaboration develops, and it often leads to new activities, services, and/or processes.

Summative evaluation provides summary information about the **results** of interagency linkages after they have been established for some time. It seeks to answer such questions as, What results are we getting for consumers and families? How is the collaboration benefiting the collaborating agencies?

Summative evaluation information involves judgments about the worth of interagency activities and is useful for making changes in how participants deliver services, manage the collaboration, train staff, and/or share interagency resources. A three-year evaluation and an evaluation of a first group of program completers are examples of summative evaluation.

Both formative and summative activities are needed for a comprehensive evaluation.

Measures of the benefits of service coordination are also categorized--this time into three groups: inputs, processes, and outcomes.

Inputs refer to resources put into the planning and operation of the program. They include resource contributions from each collaborating agency--staff, funds, equipment, transportation, consultation time, space, and other requirements. Inputs also include the ways in which participants structure the interagency activities, the selection of consumers to be served, and the types of services (interventions) they deliver.

Here are some examples:

- At the **individual level**, consumers are the primary inputs for the interagency partnership.
- At the **interagency level**, the cooperating agencies and the resources they contribute represent the inputs.
- Inputs also include the interagency goals and objectives.
- **Informal** inputs may include family members and others who volunteer to help individual consumers, a service agency, or the service system as a whole.
- **Formal** inputs include service providers such as counselors, coordinators, teachers, social workers/case workers, administrators, and many others.

Evaluating program *processes* means examining what the interagency partnership actually does to coordinate services. Process evaluation examines services, service principles, cooperating agency activities, staffing and administrative structures, as well as service coordination policies, procedures, and guidelines to reveal information about the following:

- Whether services are being coordinated in a manner consistent with the cooperative agreement.
- Whether services are reaching the target population (consumers and families the program intends to serve).
- Whether consumers and families are receiving services and supports they're supposed to receive.

Process evaluation is an important part of a comprehensive evaluation because it enables participants to monitor and examine the total resource effort of the interagency partnership. For evaluators, process evaluation presents challenges because of tendencies to focus either too intensely or too sketchily on how agencies are collaborating.

Outcomes evaluation measures the extent to which interagency services cause desired changes in the consumer population and in the collaboration agencies. Outcomes evaluation addresses two questions: Are consumers really benefiting from the services in ways that can be measured? Are there improvements in service quality and accessibility?

Outcomes can be measured at individual and interagency levels. Measures of **individual-level outcomes** include achievement, progress, and improvements in the quality of life of those being served by the system. Measures of **interagency outcomes** include assessments of how agencies have improved coordination of their services to meet the needs of consumers, whether there is a match between processes and services and the interagency mission and objectives, and how well the system is ensuring access to services.

These two levels of outcomes differ in the directness of impact on individual consumers and families, but both are important for evaluation of interagency service coordination.

- **Individual-level Outcomes** Measures of service coordination activities intended to have direct impact on consumers are the most important yardsticks of effective interagency collaboration. Evaluators seek evidence of specific changes in clearly defined aspects of consumers' lives.

- **Interagency-level Outcomes** Interagency activities also can positively affect consumers and families indirectly by improving the service system at the organizational level. These improvements are interagency outcomes and are related to changes in the service system as a whole and are usually measured in terms of improved linkages between consumers and services.

The next two charts show you example outcomes measures, first at the individual level and then at the interagency level.

Individual-level Outcomes

Category of Measure	Example *Outcomes* Measures
Family supports and quality of home life	Beneficial changes in guardianship; changes in family structure, family supports received; increased parent involvement in interdisciplinary planning for child; parent training received; social services interventions; interagency service coordination assistance; respite care assistance; reduction of family stress; improved family relationships; and/or better family decision-making.
Early intervention	Improved infant or toddler functioning, improved health status, reduced incidents of illness, improved follow-up medical care, more appropriate expectations for child, improved diet, more time shared by child and parent/ guardian.
School-based education, training, and supports	Academic skills gained, occupational skills mastered, vocational assessments completed, integrated curriculum received, academic/vocational credits earned, wages earned, work experiences gained, diplomas/certificates received, assistive technology (and other accommodations) provided, transportation provided, service coordination support supplied.
Supports for transition to independent living, employment, or post-secondary education	Assistance with application and entry into postsecondary programs, transfer of responsibility to other agency(ies), assistance with job placement, guidance and counseling, provision of on-the-job work support and/or other vocational adjustment supports, social participation supports, assistance with housing placement, assistance with living- and/or work-site accommodations.
Quality of life in adulthood	Adjustment to adult social participation; adjustment to marriage and family life; participation in church, avocational, social, recreational, and/or leisure activities; relationships with family and siblings; evidence of citizenship.
Long-range career adjustment, independence	Career advancement and promotion, additional on-the-job training, additional certifications or licenses earned on the job, additional work responsibilities, career changes, transfers or relocations. Continued independent living and self-sufficiency; continued participation in community affairs, social, recreational, family, and church activities; continued participation in treatments or therapies needed (Erickson & Kochhar, 1991).

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Interagency-level Outcomes

Category of Measure	Example *Outcomes* Measures
Interagency planning	Cooperative agreements (formal and informal); joint service assessments; joint projections of service needs and graduate placements (anticipated services); joint planning, follow-up, and follow-along activities.
Interagency training and staff development	Interdisciplinary training or cross-training activities for personnel of cooperating agencies.
Interagency community outreach and dissemination	Parent and family training activities, linkages with parent training centers and coordinated service information dissemination.
Interagency management system	Coordinated data base development to collect consumer data, coordinated information and referral services, interagency service monitoring and quality assurance activities, coordinated information-sharing among agencies, coordinated management or behavior management service, service coordination and performance management systems.
Interagency system advocacy	Individual and group advocacy to increase services and service responsiveness to consumer and/or family needs; human rights protection and review activities; local, state, and national policy advocacy for improved services.
Interagency evaluation	Interagency evaluation that involves shared consumer data collection and joint planning to use evaluation information for service coordination improvement.

Outcomes evaluation is essential if interagency planners are interested in comparing the relative effectiveness of different service coordination activities. Outcomes evaluation requires collection of baseline data--information about consumers before they received services from one or more cooperating agencies. These data are used to compare the past and present status of consumers.

Outcomes information is more useful when two more pieces of information are added:

- Data on any previous services and service results against which to compare new outcomes.

- Clearly defined goals for individual progress or performance.

Good baseline information and explicit goals permit measurement of the spreads between past performance vs. current performance and current performance vs. expected performance.

Follow-up studies are an important component of interagency evaluation and are an extension of service coordination that occurs during consumer and family participation in services.

- They provide ways of comparing progress with previous baseline data and finding out whether gains have been made by consumers as a result of the program or services remaining stable over time.
- They tell whether the gains individuals and/or families made as a result of participation in services diminish once they leave the program.
- They show whether gains made increase or accelerate once consumers and/or families leave the program.

Here are some examples of follow-up evaluation studies:

- Six-month follow-up of medically at-risk infants released from hospitals
- Two-year follow-up of preschool program completers
- Three-year follow-up of interagency inservice training program completers
- Five-year follow-up of students who enrolled in two- and four-year colleges immediately after high school graduation

Services or programs that show strong follow-up outcomes are usually judged to be worthy of continuation.

Evaluation of Interagency Service Coordination--
Measures of Performance

Whether evaluators look first at inputs, processes, or outcomes, their examination is a means to one end--assessment of interagency service

coordination. If you look at the suggestions given in each of the steps to service coordination that are the subject of Chapter 3, you'll find it easy to translate the suggestions to possible *performance measures*. The measures should encompass these categories:

- Consumer identification and community outreach
- Information and referral
- Intake and screening
- Assessment and diagnosis
- Individual program planning and development
- Service coordination and linking
- Service monitoring, progress assessment, follow-along
- Individual-level and interagency-level advocacy
- Evaluation and consumer follow-up
- Quality assurance
- Technical assistance to cooperating agencies and service providers

Cost-effectiveness and Worth of Collaborations

Cost-effectiveness evaluation helps interagency decision-makers decide whether resources are being used efficiently and whether to expand, replicate, or eliminate agency services or collaborative activities based on cost. As interagency linkages mature and expand, they should become extremely valuable to the service system. The linkages, then, can be evaluated to determine the *effectiveness* or *worth* of interagency collaboration.

In determining worth, evaluators want to know how valuable service coordination is perceived to be by the community, consumers, participating agencies, funding agents, and other interested parties. The question usually is this: Is the service coordination effort effective enough to be worth continuing or expanding? *Effectiveness* is a judgment for evaluators to make; *worth* is a conclusion for administrators, funding agents, and other decision-makers to draw. Information about effectiveness is vital to making fiscal and policy decisions about the future of an interagency relationship.

Purposes for Evaluation--They Vary

The specific questions an evaluation is to answer will affect its design and the way evaluators report results. Here are just some of the questions evaluations might answer:

Power of results
What are the positive outcomes for individuals or families? Are the goals of the partnership being achieved?

Re-evaluation of the cooperative design
Is the current interagency collaboration design still the most appropriate to meet partnership goals?

Resource development
Are the shared resources still adequate to continue the interagency partnership according to its current design?

Project replication
What elements in the current design are essential to replication?

Budget planning
How are current resources being allocated? Where are the shortfalls? Are some design elements receiving more resources than they require?

Cost-effectiveness
What do partnership leaders need to know to make sound decisions about expansion, continuation, or redistribution of resources?

Allocation of resources
Are partnership decision-makers trying to revise the way in which joint funds are being distributed among the cooperating agencies or programs?

Needs assessment
Are partners re-evaluating the priority needs the interagency partnership is addressing or are they wanting to expand their needs assessment to other groups?

Program monitoring
Are partners using evaluation data to monitor interagency activities?

Program management
Are partners using evaluation information to assess and perhaps revise management or personnel structures?

Knowing the purposes the evaluation is to serve and the audience(s) who will use the information allows evaluators to choose appropriate methods. Sometimes the information comes directly from consumers and families using the services or indirectly through agency documents or staff. A

comprehensive evaluation of service coordination activities requires use of many methods. The following list gives you a sense of the variety of methods available:

- Consumer and/or family surveys/questionnaires
- Service agency surveys/questionnaires (management level)
- Service agency surveys/questionnaires (staff level)
- Interagency coordinator/liaison surveys/questionnaires
- Interviews with consumers, families, staff, administrators, coordinators, and others
- Observations of service delivery
- Agency/site visits
- Test scores and other assessment results
- Anecdotal records
- Review of cooperative agreements and mission statements
- Review of agency budget documents and annual plans
- Review of public relations materials
- Review of short- and long-range planning documents and reports
- Review of needs assessments
- Review of individual service plans and/or program plans
- Review of family service plans
- Review of consumer and/or family records
- Review of state and local education plans
- Review of employment and training plans
- Review of rehabilitation and vocational education plans
- Review of federal, state, and local policies and of legislation affecting the service coordination partnership
- Review of personnel and/or volunteer records and job descriptions
- Review of board meeting agendas, minutes
- Review of instructional tools
- Review of orientation materials and documents
- Review of training feedback surveys
- Review of in-kind service records
- Review of admission and entry policies and procedures
- Review of interdisciplinary team meeting records
- Review of previous independent evaluations of service coordination activities
- Review of consumer complaint/grievance procedures and documents

Methodology sets content parameters, but it doesn't set content within those parameters. Whether the method is some sort of document review or a set of observations, evaluations are only as good as the questions asked.

People often view questionnaires or surveys as the easiest way to collect feedback from those involved in the service system. It is important to remember, however, that a bad survey is worse than no survey at all. Items must be categorizable, clear, answerable by those being surveyed, and relevant to the evaluation questions being addressed.

Surveys and questionnaires frequently include both quantitative and qualitative questions because both are valuable for determining the impact of service coordination at individual and interagency levels:

> ***Quantitative questions*** make inquiries about that which is countable. (How many consumers are receiving service coordination support? What is the total number of counseling hours received per consumer? How many service organizations have joined the collaboration?)
>
> ***Qualitative questions*** seek intangible measures. (How satisfied are families with their access to services? How do consumers/families judge the benefits of service coordination support? What are agency administrators' perceptions of the effectiveness of service coordination efforts? How satisfied are consumers with the amount of service coordinator contact?)

What follows is a list of questions that would likely be part of a comprehensive evaluation of an interagency service coordination effort. For each, determine whether the question is qualitative or quantitative; then decide how you might obtain an answer to the question. You may identify multiple methods for answering a single question. The first question has been analyzed for you.

Evaluation Questions

- Is the partnership linked with other education and human service initiatives in the community? *[The question seeks a quantitative response; the answer can be found by reviewing annual action plans for linking with service initiatives outside the formal cooperative agreement and by asking administrators about any informal linkages taking place.]*

- Are partnership outcomes related to state and national goals?
- Has the partnership brought together a cross-section of the community to determine priority goals for service improvement?
- Has the partnership developed an action plan for work towards meeting the national goals set by the service system?
- Has the partnership developed a method for measuring progress toward achieving community goals?

- Is there an ongoing plan to assess needs within the service agencies, schools, and community for improvement in the service environment?
- Is there a budget item for this needs assessment activity?
- Is there a plan for providing awareness of the service coordination partnership in the community, and is there a budget item for this activity?
- Is there an interagency collaboration budget and method for accounting for income and expenses for service coordination activities?

- Does the interagency partnership have a written mission statement?
- Does the mission statement define the local authorities for the partnership and include broad goals?

- Is there a documented collaboration design and specific intervention activities that are expected to produce changes in consumers and/or service agencies?
- Does the collaboration have a cooperative agreement with stated goals and measurable objectives for each goal?

- Is there a clearly defined and documented interagency management structure?
- Are there clear lines of communication and authority?
- Is there a lead coordinator or director who is ultimately accountable for accomplishing interagency service coordination goals?
- Is there a steering team or advisory group responsible for decisions about the interagency relationship?

- Is there a recruitment plan for engaging people in the interagency relationship and a budget provision for the recruiting activity?
- Is there a documented orientation plan and program? Is the program budgeted?
- Has a training program been documented? Has training been budgeted?
- Is there a documented plan for retention and recognition? Is there a budget item to fund this plan?

- How does the interagency partnership solve problems among personnel or partner organizations?
- Are there structured team meetings to address service coordination problems?
- How are problems addressed and modifications made in the interagency relationship to accommodate changes?

- Is there a plan to conduct monitoring of service coordination progress?
- Is the interagency partnership collecting information on consumers' progress in agency services?
- Is there a plan to maintain an ongoing record of the participation of consumers and/or families in collaborative agencies?
- Are there methods and strategies in place to monitor the day-to-day operations of the interagency partnership?

- Are there measurable objectives related to gains/changes in service program consumers (including families), are the objectives known by all involved agencies, and is there a process for collecting change data?

- Is there a system of follow-up to collect information on the continued progress of consumers beyond their participation in interagency services?

- Is there evidence monitoring and evaluation data are used to improve the overall service coordination effort, a single component, or a single partner agency?

- Is there evidence the partnership has resulted in system-wide improvements or gains for consumers and families?
- Is the program using resources efficiently to maximize benefits to participants?
- What are the actual costs of delivering services? What kind of return are funding agencies getting in terms of consumer progress?

The Evaluation Process--Ten Action Steps

You now know the various purposes evaluations can serve, the multiple methodologies available, and the kinds of questions that might be asked in a comprehensive evaluation of interagency service coordination. What if you're asked to help plan and conduct an evaluation of a collaborative effort? Here are ten action steps you can follow to keep you moving in the right direction:

The Ten Action Steps

1. Select your evaluation purposes and determine the decision-makers or interested parties who will participate in developing the evaluation component.
2. Select the components of the service coordination partnership that you wish to evaluate (informing the community, assessing needs, developing shared resources, creating a mission statement, designing a cooperative agreement, etc.)
3. Determine the questions you wish to answer for each of the components you're evaluating.
4. Select the evaluation methods for each question you're asking.
5. Identify and collect the available source documents that can help answer your questions (#4 and #5 are interlinked).
6. Decide on your data collection strategies (how will you undertake the methodologies you've selected?) and choose your data analysis procedures (how will you categorize/organize the data you're collecting to answer your questions?).
7. Conduct your data collection.
8. Complete your data analysis and develop draft evaluation reports.
9. Share your draft report with trusted, knowledgeable reviewers for feedback; develop your final report for distribution per the evaluation agreement.

10. See that your evaluation results are reviewed, understood, and acted upon. They should be integrated into future service coordination planning and budgeting. Have your evaluation design and methodology evaluated by users.

The last step of the action plan is the most important if you want to improve your evaluation skills. Just as you evaluate interagency service coordination efforts as a means to improvement, you need feedback from users of your evaluation to improve your next review.

Following are fourteen considerations in the design of an evaluation process. You can share them with stakeholders to apply as criteria for assessing the partnership's evaluation plan and your evaluation efforts; you can apply them as you plan and then weigh your own performance as an evaluator in the context of the partnership that is the subject of your review.

Evaluation Guidelines

- Evaluation should assist the decision-making process throughout the life of the interagency collaboration.
- Evaluation should be built into the cooperative agreement early in the planning stage and agreed to by all parties.
- Service coordination evaluation activities should start small and expand gradually; as mutual trust and credibility builds, the scope of activities can increase.
- Evaluation should be designed to support effective service coordination relationships.
- Evaluation should be flexible to allow for situational responsiveness as needs and service system environments change.
- Evaluation should be based upon shared goals and measurable objectives.
- Data collection should yield information about results and benefits for participants.
- Evaluation should reinforce and support program management and accountability.
- Service coordinators should play central roles in the planning and implementation of evaluation.
- Leadership commitment to evaluation should be communicated to all agencies' personnel.
- Preparation training for evaluation of service coordination should take place and should include all cooperating agencies.

- Interagency evaluation planning teams should include representatives from all collaborating agencies, consumers, and families.
- Cooperative agreements should include goals that are flexible and permit modification and regular review.
- Program evaluation goals and measures should be consistent with those addressed in the cooperative agreement and annual action plans.

A Point of Emphasis--Consumer Input

You've read it several times already, but it bears repeating: a comprehensive evaluation of service coordination activities seeks the judgments of consumers and families about the outcomes of interagency activities. They are the users, the only ones who ultimately can validate the quality of services they're receiving.

Wherever possible, validation should come from three sources:

Consumers participating in service programs
Examples of possible measures to be taken are consumers' satisfaction with education services and school-to-work transition services, satisfaction with postsecondary placement and supports, satisfaction with service coordinator contact, perceptions of service barriers and gaps, satisfaction with service accessibility, satisfaction with individual service goals and progress made, and satisfaction with relationships with service coordinators.

Families of consumers
Examples in this category include satisfaction with service accessibility, satisfaction with service goals and content, satisfaction with relationships between their consumer and staff, satisfaction with service coordinator contact and assistance, perceptions of personal benefits to their consumer of services received, and perceptions of service barriers and gaps.

Consumers awaiting service
Examples here include satisfaction with interim services while awaiting placement into services, satisfaction with service coordinator contact, and perceptions of service barriers and gaps.

The bottom-line justification for service coordination is better service to consumers and families. The importance of their perceptions about the quality of the service they receive cannot be overemphasized.

Evaluation as Impetus for Systems Change

Evaluation data is less likely to result in improvements unless there is a constructive process for

- analyzing and communicating the information in a manner that is understandable and usable by stakeholder groups

and

- applying the information about service system change and improvement.

The systems change process involves identifying weaknesses, deficits, barriers, and gaps in services and developing a plan to align the system with actual needs of consumer groups. Steps in analyzing and using evaluation information for systems change can include the following:

- Analyze the views of multiple stakeholder groups (internal agency staff and consumers).
- Analyze the results of the evaluation of outcomes.
- Identify discrepancies between outcomes and perceptions of key stakeholders (e.g., poor consumer outcomes but positive service coordinator perceptions).
- Share the results of the evaluation analysis with key stakeholder groups, especially the planning team/advisory group.
- Develop an ongoing dissemination and review process through which stakeholders receive evaluation results.
- Solicit direct input from consumers as part of service evaluation, planning, and development.
- Include evaluation results in annual reports of service coordination and interagency collaboration.

Evaluation is an evolving field that has as both its prime strength and weakness the ambiguity of the humanities. Measurement should be scientific, but evaluation must never be just science. Recent studies have revealed the following weaknesses in evaluation of interagency collaboration (adapted from Erickson & Kochhar, 1991):

Little standardization and low validity
Evaluation activities are inconsistent, and there is little standardization in evaluation methodology. Evaluations are conducted in settings with few controls for precise data collection. Evaluations therefore frequently have low validity and offer little accurate information about how consumers are affected.

Poor technical quality
Lack of training in program evaluation lowers quality. Evaluations are often loosely structured and superficial, yielding only impressionistic judgments of programs. Most evaluations are directed at obtaining opinion-related survey responses from internal stakeholders.

Limited instruments
Available evaluation tools range from highly subjective questionnaires to in-depth, outcomes-focused instruments. Most interagency systems engage in informal descriptive assessments that make use of only a small sector in the wide spectrum of instruments available.

Little focus on individual consumer gains
Evaluation activities are frequently focused on documenting numbers of individuals served rather than assessing individual progress.

Debilitating conflicts of interest
Agency directors are typically the primary individuals involved in designing and conducting program evaluation. The potential for biased evaluation is high. Often interagency service systems document only effects that will ensure continued program funding.

Inadequate data sources
Evaluators fail to use both quantitative and qualitative measures, fail to make adequate use of existing documentation, and fail to examine conflicting data in their analyses. Consumers and direct service providers who are closest to consumers are often omitted from the evaluation process.

Weak follow-up support
There is little evidence to suggest that once an interagency relationship has been initiated, local follow-up training or support is provided for agency staff or consumers.

Lack of focus on those most in need
There is little documentation of benefits to consumers who have the greatest need for support. Often collaborating agencies focus on documenting impacts on those who are easiest to serve or who show the best outcomes.

Monitoring methods confused with outcomes measures
Interagency monitoring methods are generally weak. Measures typically used to monitor programs are often used as outcomes measures rather than as measures to determine what process adjustments are needed as the interagency relationship develops.

The case study that follows presents a summary of strengths and weaknesses of a large collaborative partnership among public and private agencies to serve youth as revealed through a self-evaluation process. The evaluation is a straightforward critique that suggests the service system and the community are not getting their money's worth. The study shows that agencies involved in a systems change initiative sometimes need to take a hard look at outcomes and set some new directions.

The Pittsburgh Promise: A Hard-hitting Critique

(Adapted from Partnerships in Education, 1991)

The Pittsburgh Promise was established to provide career-related services to at-risk youth through junior and senior high school and to place them in full-time employment or postsecondary education The partnership was a joint venture of the Community Development Office, the Chamber of Commerce, the public schools, and a variety of community-based agencies.

As part of its mission, the partnership was to coordinate all career-related programming for Pittsburgh's citywide youth programs. The partnership's objectives were to decrease the dropout rate and create comprehensive school-to-work transition programs. There were additional objectives addressing academic performance, school attendance, youth unemployment, and adolescent pregnancy and parenthood.

Evaluation Conclusions

1. ***At the program level, the Pittsburgh Promise provided a positive work and learning experience for participating youth.*** *While data on program performance outcomes was limited (and not likely to be conclusive), reports from participants and staff indicate that students have benefited from the pre-employment programs and summer work experiences.*

2. ***The Promise also had a positive impact on the broader school environment and population in the two participating high schools.*** *These benefits came from making the goals of career awareness and preparation explicit and by providing the impetus for building career*

issues/skills into classroom instruction.

3. ***As a systems change initiative, however, the Promise had only a very limited impact.*** *There were positive gains, but the Promise had not yet resulted in any significant restructuring of programs and services in the schools or the community.*

4. ***The Promise did not succeed in serving more seriously disadvantaged youth--those most at risk of dropping out.*** *Under its current design, the Promise best served a broad group of middle-achieving youth who were already able to progress adequately in school.*

5. ***A shared vision was missing.*** *As a community-wide partnership aimed at organizing resources and commitments around a shared vision and common goals, the Pittsburgh Promise fell short of the mark. There was a general absence of both leadership and ownership at the top, little evidence of agreement on a common vision, little or no substantive discussion of the purposes of the Promise or the roles of the respective players, and no real sense of mutual and public accountability.*

The gaps between intents and outcomes were visible because the evaluators were doing their work within a framework of expectations set for the interagency collaboration when it was first established. They used as their evaluation guide the written mission and goals for the partnership.

Though the initial mission of the partnership was to target at-risk youth who were unable to benefit from the traditional school environment, the inter-agency partnership was primarily serving those in the school population with only limited need of its supports. The resources of the partnership were failing to reach the students for whom the partnership was designed. The evaluators stressed the importance of commitment from all stakeholders and the need for greater accountability for the use of resources provided through the partnership.

Some Concluding Thoughts

This abbreviated case study illustrates three key evaluation principles you need to remember:

What gets measured counts. If you're measuring irrelevancies, they'll take on undeserved importance.

What is hard to stomach is easy to bury. Don't. Evaluation exists to bring about improvement; it's nearly impossible to improve if partners are unwilling to look honestly and intelligently at what exists. Mistakes are great teachers only for those willing to learn from them.

What succeeds is worth celebrating. Perfection is a rare commodity in human service endeavors, but good people and good programs make significant progress possible. When it occurs, celebrate. For most human beings, there is no better tonic than sincere recognition of their specific contributions.

Interagency collaboration is a trend that will continue. Only through honest efforts at both the development and evaluation of interagency partnerships will partners be able to determine their real impact on consumers and families and their true value to communities.

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